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THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

BIRMINGHAM, AL

APRIL 16, 1987

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THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE

THURSDAY, APRIL 16, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Birmingham, AL.

The committee met, pursuant to notice, at 9 a.m., in the Federal Building, Birmingham, AL, Senator Richard Shelby presiding.

Present: Senators Shelby and Heflin.

Also present: Mr. Chris Jennings, professional staff member, Senate Special Committee on Aging; Ms. Tricia Primrose, legislative assistant to Senator Richard Shelby; Ms. Leslie Ludwick, press secretary to Senator Shelby; Mr. Andrew Dearman, State coordinator for Senator Shelby; and Mr. Curtis Travis, legislative assistant for Senator Shelby.

OPENING STATEMENT BY SENATOR RICHARD SHELBY, PRESIDING

Senator SHELBY. I want to thank all of you for being here this morning and I welcome you to this first field hearing for the Senate Special Committee on Aging. This hearing has got a good topic to it, I think, an appropriate one. I'm interested in the catastrophic state of catastrophic health care coverage. I'm pleased that Senator John Melcher from Montana, who is the chairman of the Aging Committee, has authorized this field hearing in my home State of Alabama. I believe this is the first field hearing of the One Hundredth Congress for the Aging Committee.

It's good to be in Birmingham. A city, by the way, that has the largest concentration of senior adults of any city in Alabama.

I'm also glad to see my distinguished colleague, the senior Senator, Senator Heflin, he is a senior citizen and a senior Senator. I am glad that Senator Howell Heflin could be with us here this morning.

Much has been said over the years and much has been written already about catastrophic illness and proposals by the administration and others for coverage. But what lies at the crux of this entire issue is the fact that the American population is getting older. And if we are to protect the seniors of today and the elderly of tomorrow against this calamity then we need to act now.

Recent statistics released by the Department of Health and Human Services indicate that life expectancy after birth has reached a new high of 74.7 years. For example, the Alabama State Data Center projects that from 1987 to 1995 the percentage of the

over age 85 population will rise 50 percent, from approximately 33,000 people here to 50,000. Not only is the number of people in the over age 65 population growing, but longevity is also on the rise. This, of course, is a wonderful thing. We all want to live long, healthy lives. But if we are to truly enjoy our golden years we need to erase the fear of catastrophic illness from our minds.

I have three objectives that I hope together we can achieve through this hearing. First, by holding a field hearing in Birmingham, I'm hoping to alert not just the elderly of Alabama, for they are basically a truly informed group, but the entire population of Alabama as well, to the devastating problems associated with catastrophic illness. The public needs to know what proposals exist in the Congress, what services are available to them now and how they can best protect themselves from the indiscriminate disruption of a catastrophic illness.

Second, by listening to our distinguished panel today, I'm hoping we can learn what services currently exist on the community level for seniors and what associated problems are apparent and ensuring that our elderly are properly cared for.

Finally, drawing on the expertise of our panels, I want to clarify what requirements for services, research and education must be met to formulate an effective, yet, physically responsive catastrophic health proposal.

On January 27 of this year, during his State of the Union Address, we received word of the President's intention to offer a catastrophic health care proposal. While I must commend this administration for taking this first step, I believe this proposal is just a cornerstone for an eventual building that we have to construct. What we in Congress need to do is to address the issue in the most constant, comprehensive and yet, coordinated way possible. Already the House Ways and Means Committee on Health has voted out their recommendation as to what the catastrophic package should include. While this legislation represents a step forward beyond the administration's proposal, I believe it's still limited in scope. It's my strong belief, that before any such legislation is passed, all options must be closely evaluated and incorporated into a more encompassing plan. Cooperation between the Federal Government, State governments, insurers and medical providers is a priority if the plan is to succeed.

Results from this legislation would be much more responsive to the needs of the elderly and more in line with the very real budget restraints we face in the Congress and more adoptable to the demands of a graying population. We need to have the foresight to pass legislation that will not only help the 28.5 million people over age 65 in America, of which close to three-quarters of a million are Alabamians, but the under-65 population as well, who are also at risk. Our legislation must be more than just a quick fix. We need to possess the vision necessary to anticipate the Nations' health care coverage needs well into the next century.

The demand for long-term and community-based care is increasing steadily. Currently, 1.5 million Americans reside in nursing homes. This figure is expected to jump to 2.2 million by the year 2000—and by the year 2040, 4.5 million Americans are expected to be in nursing facilities. In addition to these startling figures, 5.2

million over age 65 Americans with a chronic condition, require some assistance in performing the activities of daily living that help them maintain their independence. These numbers are expected to reach 7.2 million in the year 2000 and 14.4 million by the year 2050.

These needs, which are so clearly linked with the whole conception of a catastrophic illness, are the best indicators of the type of coverage we need to provide in any proposal considered.

For a moment let us turn to the economics of this situation. There is a tremendous financial burden associated with the previously mentioned figures for institutional care. To my right, is a graph [1] that shows the breakdown of out-of-pocket costs for the elderly in excess of $2,000. As is clear from the abundance of the bright red color, the nursing home section at 81.2 percent is clearly the largest piece of the pie.

But what does this mean? Well above and beyond the substantial sum of $2,000 in medical costs, the majority of the health care costs of the elderly go for nursing home care. Obviously, there is a pressing need to include long-term care in any proposal and a need to re-evaluate the out-of-pocket expenses cap in the proposals currently before Congress.

The graph on my left [2] displays the "dollars and cents" aspect of catastrophic illness. The chart indicates the annual out-of-pocket medical expenses for Medicare beneficiaries. We can see that the Medicare beneficiary who has medigap insurance, has medical expenses of $21,096 for just 1 year of nursing home care. Under the Reagan Administration's proposal this Medicare beneficiary, who has a medicap policy, is still paying $21,096 on nursing home care in 1 year. The Administration's proposal does nothing to ease the financial burden of this truly catastrophic case.

If the Medicare beneficiary we have been talking about could not afford this amount, then, under the present system, he or she would be forced to "spend down" their life's savings before becoming eligible for Medicaid assistance for nursing home care.

We should not allow catastrophic illnesses to penalize the elderly for a lifetime of hard work and saving. We should not take away the financial and psychological independence of any couple or family, when one member becomes seriously ill. We should not allow a catastrophic illness to dictate poverty to any American.

Yes, catastrophic illness has found the vulnerable segments of our population and it's the elderly and the uninsured under age 65 American who won't be able to escape unscathed.

It is my sincere hope that the testimony heard today and submitted for the official hearing record will provide a valuable tool for the further analysis of this issue in the 100th Congress. I know that we'll walk away from Birmingham today with a clearer understanding of catastrophic illness coverage and the ways in which we can be more responsive to the cries of help from a large portion of our Nation's population.

At this time, I'm going to call on Senator Heflin who needs no introduction to any of you, Senator Heflin.

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[1] See p. 44.
[2] See p. 46.

STATEMENT OF SENATOR HOWELL HEFLIN

Senator HEFLIN. Thank you, Senator Shelby. I first want to congratulate you on having this field hearing of the Committee on Aging of the U.S. Senate in Birmingham, AL.

You know, now that we have a Democratic majority in the Senate, the Senators from Alabama will be holding more field hearings in Alabama. I think it is appropriate that we have field hearings on matters dealing with the aging. I think we have entered a new era relative to the aging. Certainly, the days of those efforts to cut Social Security have passed. And now, I expect that this new era will focus on efforts to improve the quality of life of our senior citizens.

I would like to say, that Senator Shelby has started off in the U.S. Senate with a bang. He has made himself known already. He has established a reputation of being an extremely hard worker, interested in his committee work and interested in the affairs of this Nation and has taken an active part in the debate on the floor of the U.S. Senate. I congratulate Senator Shelby for his fine work. I know that he is going to be one of the truly outstanding Members of the U.S. Senate. I look forward to working with him as a partner for Alabama and as a partner for America. Particularly in order that we might try to improve the quality of life for our senior citizens.

Catastrophic illnesses have faced many, many families. They have taken the life savings of many of our senior citizens who have sought medical attention for illnesses that have occurred. We believe in Social Security. We believe in Medicare. The concept is with us and the task at hand is to improve the quality of health care for our senior citizens in a manner which is reasonable and fiscally responsible.

I think this field hearing will touch on a very important issue. Looking back over the time that I have been in the Senate, I can recall numerous floor debates on health care for senior citizens. When I ran for the U.S. Senate, I ran on a platform of providing catastrophic health insurance for the Medicare cardholders. It has taken a long time to try to get the movement going in this regard.

A few years ago, the President directed his Secretary of Health and Human Services to come up with a catastrophic health plan. And then in his State of the Union Address that he gave in January he advocated a catastrophic illness provision pertaining to Medicare. Many felt that it didn't go far enough. And one of the things that these hearings will be looking at is whether it goes far enough or are there omissions or are there things that should be included in it.

One, already, that Senator Shelby has been advocating is looking at the question of nursing homes. There are certain illnesses that need to be looked at like Alzheimer's disease and others.

I think that this hearing is going to give people who have experienced the ill-effects of Medicare, and the gravities of catastrophic illnesses, an opportunity to present their views, and a record will be made in order that the appropriate congressional committees will have your valuable testimony which will be of great benefit to those who will fashion the catastrophic health care plan.

So again, Senator Shelby, let me congratulate you on having this hearing. I hope that we can have a great number of hearings on the problems of the aging in Alabama and I know that you are vitally interested in this and will be holding hearings not only in Birmingham but other places. And I hope that this hearing will provide testimony that will be very helpful in trying to formulate a bill which will take care of the problems of catastrophic illness and will aid and improve the Medicare issue, the Medicare facilities, and the Medicare care provisions of the present law. In my judgment, this is an area that needs a great deal of exploration and investigation as well as improvement.

Again, let me congratulate you. I wish I could stay but I have to go to Winterboro. Some of you might not know where Winterboro is. Winterboro is in Talladega County. If you go to the end of the paved road, you take the third dirt road to the left to get there. So we know, it's not that bad; Winterboro is a fine community, but it is a small community. Again, I am delighted to be here and I wish you well in this hearing.

Senator SHELBY. Senator Heflin, I appreciate you coming by and participating and giving your statement regarding this. I know you're going to be all over Alabama. After this hearing today, I too, will be in Decatur and later tonight in Huntsville. And, maybe, we'll cross our paths again before we go back to the Senate Tuesday.

Senator HEFLIN. I have a written statement I would like to put in the record.

Senator SHELBY. Your written statement will be made a part of the record, without objection.

Senator HEFLIN. Thank you.

[The prepared statement of Senator Heflin follows:]

TESTIMONY ON CATASTROPHIC HEALTH CARE BY SENATOR HOWELL HEFLIN

Mr. Chairman, I appreciate the opportunity to make brief remarks regarding the need for catastrophic health care for our elderly citizens.

I want to congratulate you, Senator Shelby, for your leadership on the Senate Committee on Aging with regard to catastrophic health care.

Before I left Washington last week, the House Ways and Means Subcommittee on Medicare voted 9 to 2 in favor of legislation to protect our nation's 31 million elderly and disabled Medicare beneficiaries against catastrophic doctor and hospital bills.

As you of course know, just about everyone supports some form of catastrophic health care for our senior citizens. The measure adopted by the House Subcommittee on Medicare is based on the proposal which was first brought forward by Dr. Otis Bowen, Secretary of Health and Human Services. Dr. Bowen's proposal was later endorsed by the President.

Senator Dole has introduced the Administration's catastrophic health insurance proposal in the Senate and the measure is currently pending in the Senate Committee on Finance. The President's proposal on catastrophic health insurance is a follow up to his 1986 State of the Union Address wherein he set forth his intentions to introduce a plan to provide health care to those elderly and disabled beneficiaries who are on Medicare. The Senate version of the catastrophic health care plan represents the cumulative efforts of many who want to construct a basic approach that balances many concerns, including our continuing commitment to the elderly and disabled individuals.

The catastrophic health care proposals currently under consideration by the Congress would improve benefits for short-term nursing care in a skilled facility, and for mental health, hospital and home health care services. The proposals would also require state Medicaid systems to provide catastrophic illness protection for disabled and elderly people with incomes below the poverty line. In effect, these low income people would be free of all Medicare-related cost for health care.

The proposals under consideration by the Congress would also remove the existing requirement that in order to receive Medicare-paid care in a skilled nursing facility in connection with an acute illness, an individual first must be hospitalized for at least 30 days. I think this old law of requiring a patient to be in the hospital for at least 30 days is archaic and I am delighted that the new catastrophic proposal would eliminate this.

The measure under consideration by the Congress would also change the allowed number of days in such a facility from 100 days per illness to 150 days a year and reduce the current out of pocket co-payment for such days from about $65.00 a day to $24.00 and make it payable only for the first seven days of care. I must say I have some problems with this aspect of the proposal. To my way of thinking, if the attending physician certifies that an elderly person needs to be placed in a skilled nursing home, the individual should be eligible to receive this care for an extended period of time based on what the attending physician prescribes. I do, however, support the portion of the proposal which reduces the amount of the co-payment that the elderly must pay.

The catastrophic health care measures pending in the Congress would increase the number of free home health visits for Medicare beneficiaries by health professionals from 21 days annually to 42, and also increase the maximum mental health benefit paid by Medicare from $250 a year to $1,000. The limit of 210 days of free hospice care for terminally ill Medicare patients would be removed.

I want to say at this point that I wholeheartedly support adequate catastrophic health care coverage for our elderly citizens. This year, Medicare will spend almost $80 billion on medical care for the elderly but out of pocket medical expenses for these individuals will be over $30 billion, not including long term care.

I have heard numerous complaints from senior citizens saying that when they have reached a point in their lives when they can no longer take care of themselves at home, they are confronted with the horrible choice of dying or giving up their life savings and their homes in exchange for going into a nursing home. Where does this leave the elderly spouse?

For low income elderly, the cost of catastrophic illness can quickly wipe out a life time savings, leaving huge debts to be paid. Last year, over 20% of senior citizens spent at least 15% of their income on their medical bills, and 7% were forced to spend 25% of their income on medical bills.

It is clear to me that the so-called Medigap or private supplemental insurance policies are not meeting the catastrophic needs of the elderly. Fear of bankruptcy from a catastrophic illness has driven 70% of senior citizens to buying Medigap insurance. But the elderly believe that many of these policies are of questionable value. Many policies do not cover the elderly for preexisting health conditions. In addition, some of the premiums are so high that the elderly can ill-afford to pay the cost of an insurance policy.

Congress needs to expeditiously adopt catastrophic health care for both Part A and Part B of Medicare, in order to give peace of mind to our nation's elderly citizens.

I intend to work hard to see to it that legislation is adopted by the Congress this year to provide better health and financial security to our senior citizens. We need to do all that we can to help our senior citizens meet the problems of prescription drug cost, long term care in nursing homes and doctor bills.

I want to see a bill passed by the Congress which will cover long term care in nursing homes for Alzheimer's patients, stroke victims, those with heart disease and others.

It has become increasingly more apparent to me that we must begin to focus on long term care for the elderly. Long term care has become the fastest growing segment of the U.S. health care industry. Average annual increases in our national expenditures for nursing home care consistently exceeds the average for all other expenditures including hospital care. Today, responsibility for long term care services is shared almost equally by the public and private sectors. Public responsibility for long term care is mainly confined to the Medicare program which pays about 42% of all nursing home bills. But of the remainder of this bill, more than $18 billion comes directly from the pocketbooks of patients and their families. Private insurance plays almost no role in the financing of long term care, nor does Medicare.

Congress must adopt a measure which will allow Medicare to completely cover nursing home care for the elderly.

The legislation currently pending in the Congress pertaining to catastrophic health care coverage is certainly not a panacea, but I believe it is something that we can build upon. I am delighted that the Administration and the Congress are beginning to address the problems of the gaping holes in the Medicare program and these

holes must be quickly filled if we are to keep Medicare's promise of not allowing high health care bills to jeopardize life long plans for a secure and dignified retirement.

We need to address the problem of there being no upper limit on the out of pocket expenses that senior citizens must pay for services covered by Medicare. To my way of thinking, the present program's is awful because expenses paid by the most seriously ill elderly individuals begin to rise sharply after 60 days of hospital care when costly charges must be paid for each additional day of care, and on top of these expenses, the Medicare program is filled with too many loopholes and confusing limitations which scare the elderly to death.

As we begin to consider the catastrophic health care coverage, we must develop an affordable way to pay for catastrophic illness, particularly, for those elderly individuals who are more susceptible to high health care cost.

Mr. Chairman, as the Congress seeks to develop a new health care catastrophic plan, we need to make sure that whatever we provide is thoroughly understood by our senior citizens and that we do not put out some complicated, bureaucratic complex program that is difficult to understand. I think an important goal of catastrophic health care coverage should be to find a method to simplify the existing Medicare plan and give the elderly some kind of assurance of what benefits are covered and what their obligations are whenever health care services are needed.

Mr. Chairman, again, I am delighted that you have given me the opportunity to share my views and concerns regarding the need for catastrophic health care for our elderly. I intend to fight on the Floor of the Senate for adequate health care coverage for our senior citizens when I return to Washington next week.

Senator SHELBY. At this point I would like to make Senator Melcher's statement part of the record. Senator Melcher is a Democratic Senator from the great State of Montana, and I serve with him on the Aging Committee. He has graciously permitted me to conduct this field hearing for the committee—the first one in Alabama. I am also pleased to have some members of the Special Committee on Aging staff here with me from Washington, in addition to a number of staffers from my own Senate office.

[The prepared statement of Senator Melcher, chairman, follows:]

PREPARED STATEMENT OF SENATOR JOHN MELCHER, CHAIRMAN, SENATE SPECIAL COMMITTEE ON AGING, "THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE"

As the Chairman of the Senate Special Committee on Aging, I would like to take this opportunity to commend Senator Shelby for taking the initiative to hold the first Aging Committee field hearing of this historic 100th Congress. Ever since he joined the Senate Aging Committee—from our very first meeting this past January through every hearing we have held—it has become clear that Senator Shelby's strong commitment to older Americans will make him one of the most active and effective members on the Committee.

The title of today's hearing is particularly appropriate. The state of catastrophic health care coverage certainly is a catastrophe. Despite what as many as 80 percent of the elderly think, Medicare does not cover the tremendous expenses (now averaging at $22,000 a year) associated with nursing home care. Indeed, Medicare also does not cover the costs of drugs prescribed outside the confines of a hospital, routine physical exams, many optical services, and hearing aids. What is even more alarming is the fact that the Administration's so-called "catastrophic" health care proposal does not include any protections against any one of these catastrophic costs.

To address the catastrophic health care cost issue, the Administration proposes a plan which would protect those relatively few Medicare beneficiaries (between 3 to 4 percent) who experience a prolonged acute condition within the confines of a hospital and who must pay over $2,000 out of their own pockets for Medicare deductibles and coinsurance. However, because this plan would not cover such expenses as nursing home care and prescription drug costs, it is misleading to say that the proposed $2,000 annual cap would protect older Americans, particularly elderly individuals of limited means, from catastrophic health care costs.

It is an unfortunate truth that the Administration believes it doesn't need to or can't go any further in this area. Well, in my mind, this step forward is not the step of the world's richest and most compassionate nation, but the step of a mouse.

As the baby boom becomes the senior boom, much greater demands will be placed on all segments of our health care industry. Although only about five percent of the elderly are in nursing homes at any given time, 25 percent will need long-term care assistance during their later years. In addition, the likelihood for institutionalization increases with age. In 1985, an estimated 2 percent of the 65-74 population versus 16 percent of the over 85 population was in a nursing home. The fact that the over '85 population is the fastest growing age group in the nation (projected to increase seven times between 1980 and 2050) has tremendous implications for public health policy.

Unlike the Administration, I refuse to turn my back on this ever-increasing population and ever-increasing need of older Americans. Simply stated, legislation which does not include expanded federally-sponsored long-term care coverage should not bear the name of "catastrophic protection."

In the upcoming months, we all must work together to fight for the inclusion of long-term care protection. To accomplish this goal, we must educate the general public about the shortcomings of Medicare and the Administration's proposal. We must impress upon them the need to contact their representatives in Congress to let them know how important this issue is for them and the country as a whole.

There is no question that it will be difficult to find the funding we need to pay for necessary long-term care coverage for our elderly. However, to me, it is nothing but a matter of priorities. This issue is a priority for many if not all of today's witnesses and for Senator Shelby and myself. If all of us do our jobs, it will become a priority for the general public, and as a result, the rest of the Congress and the Administration.

The witnesses assembled here will make an important contribution to our shared goal of protecting all Americans, including older Americans, against the burden of catastrophic health care costs. It is therefore with great anticipation that I look forward to reviewing the testimony given to Senator Shelby at today's hearing.

Senator SHELBY. We're going to have a number of witnesses and different panels to testify. I'm going to call on Dr. William Bridgers. A lot of you know Dr. Bridgers, he is the Dean of the School of Public Health at the University of Alabama in Birmingham.

Dr. Bridgers, if you would just come to the witness table. We're certainly proud to have you participate in this field hearing. This is a discipline that you know a lot about. You have spent your life in it and you're recognized nationally on a lot of these issues. And I look forward to continue to work with you on a lot of issues regarding health as I did in the U.S. House.

Dr. Bridgers, your written testimony will be made part of the record in its entirety, as Senator Melcher's, Senator Heflin's and my own statement was.

And if you would sum up orally your statement and then open it up to any questions or comments. We welcome you here.

STATEMENT OF WILLIAM F. BRIDGERS, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Dr. BRIDGERS. Thank you, Senator. I am William Bridgers, Dean of the School of Public Health at the University of Alabama at Birmingham. I also serve as the Director of a new Center for the Study of Health Policy named in honor of one of your precedessors, Senator Lister Hill. That's an effort, for which, by the way, your colleague Senator Heflin was instrumental in helping secure Federal funding from this last session of the Congress. Were the great Senator still with us, he would applaud the efforts of yourself and others who have determined that the time has come for surfacing again the current major gaps, and our attention to, coverage for catastrophic health care. I want to thank you for asking me to participate. And I thank you for holding this hearing here in Birming-

ham, home of one of the Nation's premier academic health centers, one very active in caring for a lot of people who are unfortunately part of the burgeoning statistics of catastrophic illness and injury.

As Secretary Bowen defined it in his report to the President, catastrophic care refers to illness cost which cannot be borne by individuals or families without having to significantly change their lifestyles or drastically modify their expectations of their living standards in the future. By this definition, the poor, the underemployed, and the underinsured are especially vulnerable, and this area of the country is historically one with many such people.

Although indigent care and catastrophic care may be debated as separate policy issues in States such as ours, they have become one problem all too often. If reality is that an individual must spend down to Medicaid eligibility before outside help is available, it is clear that even many employed persons are in fragile financial positions from which they may not recover if catastrophic illness strikes. This threat of being forced to spend down may be the most ominous in the minds of people at risk for a catastrophic episode.

It seems to me that the numerous potential options under discussions by the Congress, and the report to the President from Secretary Bowen had 30 some odd pages listing those options, need to be examined through a wide-angle lens in the broad context of public health policy. And as a teacher, analyst, and minor participant in health policy development, I can state my bias: If I can sum it up in a sentence, it is to worry a little more at this time about the health of the people and a little less about the financial health of the health care system. Measures to enhance the health of the people will, in fact, enhance the health of the system.

It's important to note that catastrophes can occur literally from cradle to grave, from the premature infant requiring a $150,000 worth of high technology just to get a start in life, to the 75-year-old widow faced with the need for a nursing home that Medicare won't cover.

I'm pleased to note that the Special Committee recognizes the breadth and depth of the problem; that it does, indeed, extend from neo-natal intensive care to the hospice, although it is understandable that the immediate attention is on the facets that are most relevant to Medicare. Whereas the main focus is to how to place a stop-loss on an individual's financial risk, I see it as an opportunity to consider another stop-loss: what, if anything, can be done to prevent these catastrophes? Let's not spend all our energies and our money to pay the piper after he has played his tune.

One cause for the increase in the problem is attributable to one of the new sleeping giants of public health, namely our success in extending life expectancy, resulting in a rapidly increasing population. Many of the diseases that account for a high percentage of catastrophic episodes are, in fact, acute exacerbation of chronic diseases and are potentially preventative or postponable. The latter concept of postponement is of great economic importance because, for one thing the average 65-year-old still has a life expectancy of some 17-plus years, and it is known from studies carried out by HCFA that the cost of treating life threatening events declines with age, contrary to a widely held view. It is a fact that the cost to Medicare of the last year of life is lower the older one gets. The

cost per year for survivors increases with age; the very much greater cost for succumbers declines with age. Obviously, prevention and postponement have rolls to play that have been ignored or at least overlooked.

One of the flaws in Medicare evident since its adoption in 1965 is that it contains a specific prohibition against reimbursement for most preventive services. Medicare will pay for radical mastectomy, but not for screening with mammography for the early treatable breast cancer. Medicare will pay for treating a victim with a stroke, but not for routine control of hypertension that might have prevented it.

In the light of current evidence on the value of prevention, it makes no sense that Medicare not recognize and pay for these values of risk assessment and low tech preventive interventions.

I have two suggestions: First, an "entrance exam" when one becomes Medicare eligible is appealing as a way to begin the prevention-postponement thrust. The great majority of people entering their Medicare years are healthy and robust, yet that they may not know about their risks, already apparent to a good clinician. And they may not, therefore, know, which specific actions or activities they need to engage in in order to reduce these risks. A careful appraisal of risks could be carried out by any competent primary care physician.

In my submitted statement I have listed some of the items that should be included in the risk assessment. One benefit of the entrance exam would be to afford HCFA and other analysts data on which projections in the future could be based. Presently, most estimates on future outlays are based on past experience of users rather than on the health status of the universe of beneficiaries. These simple tests would also afford not only a base line from which to evaluate events in the future, but would open up the opportunity to offer advice on risk reduction. Most people are motivated by their doctor's "individualized advice."

A reasonable guess on the cost of the entrance exam is about a $100 for males and $150 for females, for a total cost to Medicare of about $250 million a year. This sounds like a lot until placed in the context of the $77-plus billion annual outlay for Medicare. It is not a rounding error, but nevertheless, it is only about three-tenths of a percent. This cost could, and probably should, be spread over all Medicare beneficiaries because they all—indeed, all of us, stand to gain from the savings brought about by reductions of catastrophic episodes. These costs could be covered as one option with an add-on of less than a dollar per month to the Part B premium. I suggest this idea receive consideration as a compliment to whatever stop-loss provision is ultimately adopted.

In order to prepare for this new prevention era for Medicare, I recommend that as a first step consideration be given to the establishment of a Commission for Preventive Services, a rough counterpart of ProPac. This body of experts, which would need input from other agencies which I named in my submitted testimony, could keep HCFA and the Congress updated on new preventive technologies and on their cost, and they could weed out ineffective or outmoded strategies.

In closing, may I note that these very modest changes of Medicare could teach us how to most effectively incorporate a prevention service system into our very fine, albeit very expensive, therapeutically oriented health care system. The payoff could be not just financial health, but, indeed, our health status itself. Thank you.

[The prepared statement of Dr. Bridgers follows:]

TESTIMONY BEFORE A HEARING
CHAIRED BY SENATOR RICHARD SHELBY,
MEMBER OF U.S. SENATE SPECIAL COMMITTEE ON AGING

April 16, 1987, in Birmingham, Alabama

William F. Bridgers, M.D.
Dean, School of Public Health
University of Alabama at Birmingham

I am William Bridgers, Dean of the School of Public Health at the University of Alabama at Birmingham, and Director of a new center for the study of health policy named in honor of one of your predecessors, Senator Lister Hill: The Lister Hill Center for Health Policy. Were that great Senator still with us, he would applaud the efforts of yourself, other members of the U.S. Senate Special Committee on Aging, many others in the Congress, and those in the Executive Branch, who have determined that the time has come for surfacing again the current major gaps in our attention to, and coverage for, catastrophic health care.

I am honored that you have asked me to participate in this, your first chairing of a hearing in your role as a new member of the Special Committee, and it is especially significant that you are holding the hearing here in Birmingham, home of one of the nation's premier academic health centers--The University of Alabama at Birmingham--a medical center very active in caring for a lot of people who

are unfortunately part of the burgeoning statistics on catastrophic illness or injury.

As Secretary Bowen defined it in his Report to the President (Catastrophic Illness Expenses, Department of Health and Human Services, November, 1986) catastrophic care refers to illness costs which cannot be borne by individuals or families without having to significantly change their life styles or drastically modify their expectations of living standards in the future. They may face eventualities such as losing their homes, terminating their plans for a college education, or living out their days impoverished in a nursing home.

By the Bowen definition, the poor, the underemployed, unemployed, and/or underinsured are especially vulnerable, and this region of the country is historically one with many such people. Although indigent care or uncompensated care and catastrophic care may, strictly speaking, refer to different phenomena, in states such as ours they become one problem all too often. If the reality is that an individual must "spend down" to Medicaid eligibility before much outside help becomes available, and taking into account that Medicaid eligibility in Alabama is presently set at 16 per cent of the Federal poverty level, it is clear that even many employed persons are in a fragile financial position from which they may never recover if catastrophic illness

strikes. This threat, of being forced to spend down, may be the most ominous in the minds of people at risk for a catastrophic episode. Nursing home care illustrates this point all too well. For those Medicare eligible, this program covers only 2 per cent of the nationwide yearly expenses. Private insurance covers only half that much, Medicaid covers about 42 per cent, and patients pay for half of the total. It is obvious from these figures that impoverishment is virtually a precondition before most can be assured of receiving financial assistance with nursing home care. And, of course, the need for nursing home care often leads, sooner or later, to the meeting of this precondition.

My testimony will focus on the problem of catastrophic care only from my perspective: public policy, health policy, public health, or to put it all together: public health policy. I am not a clinician caring for individuals suffering with acute or chronic catastrophic disease, nor am I a health economist or expert on the financing of this care. There have already been several hearings highlighting these important aspects, and there will be many more that will contribute to the debate on what, when, and how to do something about the problem. As Secretary Bowen pointed out in his Report to the President, "The options that can be developed to enhance catastrophic illness coverage for Americans are for all practical purposes limitless." He

devotes over 30 pages (of a 117 page report) to them, and no doubt there are others and combinations that could be added. It will be extraordinarily challenging for the political process to select the options which are at once adequate, equitable, economical, and not too disruptive in terms of the cascade of effects upon other facets of the system, such as primary care, private insurance, Medicaid, maternal and child care, etc.

It seems to me that all the potential options under discussion in the Congress need to be examined through a wide angle lens in the broad context of public health policy, and as a teacher, analyst, and minor participant in health policy development I can state my bias: if I could sum it up in a sentence, it is to worry a little more at this time about the health of the people and a little less about the (financial) health of the health care system. If we as a nation were to suddenly find the silver bullet which led to success in bringing the U.S. health service system's costs under control, but this came about at the expense of large numbers of people effectively locked out of the system, we would have achieved not success but failure. That, I am now convinced, we will not let happen. Ten years ago, perhaps even five, if one timidly suggested that it was time to come to grips with an <u>expansion</u> of coverage for those presently denied optimal use of the system, the response would have been: not now; not until costs are

contained. It is heartening that we've matured beyond that reflexive rejoinder.

In our race after costs, not unlike those sleek dogs at the track hot on the heels of the mechanical rabbit, gaining on it but not quite catching it, we now glance over our shoulders and notice that some of the participants have slowed down, and some have fallen by the wayside. Notably, we see that the numbers of the potentially medically indigent, of those underemployed or underinsured, threatened with the spectre of an inability to purchase care, should it be required, are increasing. The uninsured now number over 30 million and it could be that one in three of us are potentially medically indigent (based upon our capacity to cope financially with a devastating illness). A number of people--even those who tried to plan for their futures--could have their dreams shattered by the spectre becoming a grim reality: a catastrophic illness or injury. It is often stated that in any given year the probability of any one family having to deal with one of these catastrophes is small. True enough, but that is not the relevant question to ask. Rather, what's the probability over 3 years, 10, or 15? If we had the data, there's little doubt that the proportion of families at risk over any reasonable period of time is substantial.

These realities have, I believe, also caused us to pause--not as a manifestation of our failure in our health policy but as a reaffirmation of our fundamental egalitarian precepts. The public dialogue has now reached a new plateau: not whether to lend a hand, but how. This, I believe, represents a maturation in our deliberations.

Presently, we subsume much of this concern under a broad and somewhat vague term of catastrophic health care coverage. (It might be helpful at this point in the debate if someone could coin a three letter word for catastrophic care. We seem to prefer to debate policy options, even very complex ones, by referring to them by initials: DRG, HMO, PPO, IPA, and PRO, being good recent examples.) The catastrophes can occur literally from cradle to grave: the premature infant requiring $150,000 worth of high technology just to get a start in life; the young child requiring a liver transplant or the college girl requiring a new kidney; the high school boy with a severed spinal cord from diving into a pond and guilty of nothing more than youthful exuberance; a young adult at the height of his creativity struggling with his own immune system in a hopeless battle against AIDS; a prematurely failing heart in a middle aged business man; a nun with metastatic cancer of the breast; a 75 year old widow faced with the need for a nursing home that Medicare won't cover.

All of these, and many more from the neonatal intensive care unit to the hospice, fit the definition of catastrophic health care coverage sorrows. I am pleased to note that the Special Committee recognizes the breadth and depth of the problem, although it is understandable that most of the immediate attention is on the aspects of it most relevant to the elderly and other Medicare beneficiaries. Secretary Bowen took a bold step in bringing this to the front burner as one aspect of our social security that cries out for attention. Many have joined him in support of the idea that the time has come, although how far to go in coverage and how to pay for it is far from settled. Some see it as a straightforward issue in how to go about placing a stop-loss on an individual's risk of financial catastrophe. Some view it as step one in facing the music: the inevitability of the need for rationing certain kinds of care. Let us hope that that dismal possibility does not loom too large too soon. Some see the initiative as another step closer to the slippery slope of national health insurance. I see it as an opportunity to ask an important question: from the public health perspective, what, exactly, are the causes of these catastrophic episodes and their high costs and <u>what</u>, <u>if anything</u>, <u>can be done to prevent them</u>?

While we worry through how to pay for this care, let's give equal time to the causes and to the potential for intervention <u>before</u> the fact. From one view, the reason why

catastrophic illness is now such a massive problem is because we're now capable of intervening with high technology diagnostic and therapeutic tools and skills not even imagined a few years ago. Another cause is attributable to one of the new sleeping giants of public health: our success in extending life expectancy, resulting in a rapidly increasing population of elderly people--most living fulfilling and vital lives, but at risk for a high tech catastrophe, or, even more commonly, a low tech one, such as nursing home care.

This facet of the system--nursing homes--is no longer viewed as just a place to warehouse old, worn out people but as a site for restoration--a temporary abode and not the final rusting place. I will interject here a suggestion that deserves exploration by the Congress. We seem about ready to face the need for more nursing home and other chronic care beds at the same time that we are not facing the fact that we have too many acute care hospital beds. (With nationwide occupancy running around 60 per cent, and even ignoring the evidence of a significant number of medically questionable admissions, it is obvious that we're all paying the acute care hospital sector quite a lot to maintain those empty beds.) One could wonder to what extent it might be possible to convert unneeded acute care beds into needed chronic care beds, saving on both sides: less outlays for empty acute care beds and less outlays for

construction of needed chronic care beds. To my best knowledge this sort of tradeoff has not been studied adequately by the private sector or by the Congress. (The concept of "swing beds" being experimented with in some rural areas may be more an attempt to have one's cake and eat it too than to find a definitive solution. At any rate, so far as I know even the swing bed notion has not received much attention outside rural America.)

Before I return to my main thrust on the need to look to prevention or postponement as one valid strategy in dealing with catastrophic illness, let me say a bit more about their causes. It is customary to classify chronic, debilitating disease into groups. First are those resulting from self-imposed risks such as smoking or other self-destructive behaviors. Second, there are those resulting from societally-imposed risks such as exposure to asbestos and other toxics, including numerous chemical or physical risks in the environment, including the air, the water supply, the food chain, the workplace, and even the home. Third, we shouldn't overlook those coming about as a consequence of the health care system itself, such as drug reactions or diagnostic or therapeutic mishaps. And finally, there is a category of causes that are, simply, a matter of luck. This seemingly unscientific classification is really quite useful: one's luck begins when one's parents are chosen: genetic potential for, or protection

against, a host of disease conditions is not a matter of choice, but luck. Other conditions as much attributable to luck as to any other cause would be many unintentional injuries, whether one is born rich or poor, whether one is unknowingly exposed to risks for toxic shock syndrome, legionnaires or AIDS (to name but a few recent examples), and the list could be expanded. To a significant extent, many medical catastrophes fit into this criterion of, simply, bad luck. We as a nation have a long history of helping those who have been dealt a bad hand by lady luck.

I mention this simplified classification of causes because in pondering a solution to the problem of catastrophic care we need a dual thrust: a way to pay for them when they occur, while at the same time taking positive steps to reduce their incidences. We know from studies from, for example, the Carter Center that up to two thirds of premature mortality (arbitrarily defined as death before age 65) is potentially preventable. All our attention should not be devoted to how to pay the piper after he's played his tune.

To a significant extent, many of the diseases that account for a high percentage of catastrophic episodes (cerebrovascular accidents, or strokes; congestive heart failure; septicemia; malignant tumors; chronic obstructive pulmonary disease; coronary artery disease; diabetes;

chronic renal disease; accidents) are acute exacerbations of chronic disease and are potentially preventable or postponable. The latter concept, of postponement, is of great economic importance because it is known from studies carried out by the Health Care Financing Administration that the cost of treating life threatening events declines with age, contrary to the widely held view. (Apparently, less heroic measures are taken when a very serious illness becomes manifest in the very old than when it occurs in those under 65 or in the youngest of the old. Whereas the reasons for the decline may not be fully understood, it is a fact that the cost to Medicare of the last year of life is lower the older one is at that time. The cost per year for "survivors" increases with age; the very much greater costs for "succombers" declines with age.)

Should it not, therefore, be considered prudent public policy to couple the insuring against catastrophic illness with companion provisions that attempt to prevent them from taking place or at least postpone them? The answer is, "it depends." If the start-up costs are not too great and there is a reasonable probability of a savings down the road, it's worth consideration. I believe the evidence is very favorable, and I have a suggestion on how to start this preventive initiative.

An "entrance exam" when one becomes Medicare eligible makes sense as a way to begin the prevention-postponement thrust. The great majority of people entering their Medicare years are healthy and robust, yet they may not know about the risks already apparent to a good clinician and they may not therefore know which specific actions or activities they need to engage in in order to reduce these risks. A careful appraisal of risk could be carried out by any competent primary care physician. This would include measurements of height-vs-weight, visual and auditory acuity, blood pressure, blood cholesterol and lipids, mammography in females, a careful history of symptoms of preclinical or manifest disease states, and an appraisal of personal habits of nutrition, self-prescribed drug taking, and substance abuse. These and other simple tests would afford not only a baseline from which to help appraise events in the future but would open the opportunity to offer advice on risk reduction. Some might ignore the advice, but most people are motivated by their doctors when given individualized advice, whereas they might be confused by the barrage of free "advice" they receive from advertisements and articles in the lay press. If they can see that certain risk factors apply to them and not just to all those others their age they might heed the advice. (It has been called to my attention that the Harvard Medicare Project (Medicare: Coming of Age, A Proposal for Reform, Cambridge, MA, Harvard Press, 1986) calls for an annual physical limited to much

the same items as I have noted, estimated by them to cost about $1 billion per year. I question whether a full risk assessment workup could be carried out that inexpensively.)

The cost of an entrance exam for new Medicare beneficiaries? A reasonable guess is about $100 for males and $150 for females. Because each year about 2 million people become Medicare eligible, the total cost to Medicare would be about $250,000,000 per year. This sounds like a lot until placed in the context of a $77+ billion annual outlay for Medicare; it certainly isn't a rounding error but nevertheless is only about 0.3 per cent. It makes sense to spread this cost over all Medicare beneficiaries because they all, indeed, all of us, stand to gain from the savings brought about by reductions in catastrophic episodes. This cost could be covered by an add-on of less than a dollar per month (to the Part B premium). I suggest this idea as one deserving consideration as a coupling to whatever stop-loss provision is ultimately adopted.

In closing, may I note the real, fundamental problem and an opportunity. One of the flaws in Medicare, evident since its adoption in 1965, is that it contains a specific prohibition against reimbursement for preventive measures (with the recent exception of coverage for pneumococcal vaccine and flu shots). Medicare will pay for radical mastectomy but not for screening with mammography for early,

treatable breast cancer. Medicare will pay for treating a victim of stroke but not for routine control of the hypertension that might have prevented it. In the light of current evidence on the value of prevention, it makes no sense for Medicare not to recognize, and pay for, these values of risk assessment and low tech preventive interventions.

In order to prepare for this new prevention era for Medicare, I recommend that consideration be given to the establishment of a Commission for Preventive Services, a rough counterpart to PROPAC. This body of experts, with the needed input from other agencies such as the Centers for Disease Control, the National Institutes of Health, the Congressional Office of Technology Assessment, the Office of Disease Prevention and Health Promotion in the Department of Health and Human Services, and the National Center for Health Services Research and Health Care Technology Assessment could keep HCFA and the Congress updated on new prevention technologies and on their costs and could weed out ineffective or outmoded strategies. Such a commission could give a heightened attention and visibility to prevention, presently the stepchild of the health care system. The beneficiaries would not be just those in Medicare.

In closing, I will summarize my view of where we should go from here. I agree that the time has come to air the issue of catastrophic care and how to remove its spectre of financial ruin. I ask, however, that we not devote exclusive attention to how to pay for it, but give some attention to the power of prevention as a way to preclude some of the need to pay. I propose a modest change in Medicare, but a change which could teach us how to most effectively incorporate a prevention services system into our very fine, albeit very expensive, therapeutically oriented health care system. The payoff could be not just our financial health but indeed our health status itself.

Thank you.

Senator SHELBY. Dr. Bridgers, we certainly are indebted to you, for not only your work in public health, preventive medicine that we have worked with you on in other Congresses, but for appearing here today.

Just for the record, I want to introduce, without objection, I trust, your résumé here and I want to share a part of it.

Dr. Bridgers is a graduate of the University of the South, received a Bachelor of Arts degree in German, studied bio-chemistry in post-graduate school at Duke University. Attended Washington University School of Medicine, St. Louis, received his M.D. degree there in 1959. After a 2-year fellowship in preventive medicine at Washington University, he joined the faculty in St. Louis as an assistant professor of public health and preventive medicine. He served 2 years, 1966–68, at the University of Miami School of Medicine before joining the faculty at the University of Alabama in Birmingham.

Dr. Bridgers, I have several questions for you. I have some that I might submit to you in writing just for the record.[3] We'll keep open the record until April 30 for any written testimony, additions, or addendums to anything that anybody wants to put in the field record. And that, of course, includes all the witnesses.

Dr. Bridgers, anticipating the tripling of the over age 85 population by the year 2020, what are the implications this has for the Nations' health care and the support system, particularly these people and these organizations and businesses and so forth dealing with long term care?

Dr. BRIDGERS. I think the most serious spectre is this phenomenon of "spending down" that I noted earlier.

Senator SHELBY. Give us an example of this. Just a typical middle-class Alabamian or Nebraskan or Montanan or Connecticut citizen it's everywhere is it not, doctor?

Dr. BRIDGERS. Yes, sir. The scenario is usually very similar. After a person reaches a state of needing, say, skilled nursing facilities care, he or she (and more often she—we men die a little sooner)—discovers very quickly that Medicare will cover only a minuscule part of the cost of this care. Presently, Medicare covers about 2 percent of all nursing home care costs; the private insurance covers only about half of that or about 1 percent; Medicaid, if one can spend down to become Medicaid eligible, then picks up some 42 percent. And about half of the costs are borne by the individuals or their families. And I think that that is, as I said, the greatest spectre that faces the elderly as they approach the stage where chronic, supervised care may be required.

Senator SHELBY. Dr. Bridgers, have you found that many of our citizens all over the Nation, and particularly since we're here in Alabama, have been shocked that Medicare and certain insurance policies don't cover nursing home long-term extended care? They haven't had to consider it until it's on them, have they not?

Dr. BRIDGERS. I think that has been the common experience everywhere. We have called these "war stories" and they are all too real and all too common. I don't know why the public has not been

[3] See p. 30.

better informed on the limited coverage of long-term care in Medicare. And I think it's an issue long overdue. I am delighted that you and others are addressing it now.

Senator SHELBY. Doctor, I have a couple of other questions for you. It's my understanding here at UAB, where you're very active, that the University of Alabama Center for Aging has submitted a research proposal to the National Institute of Aging, NIA, for an Alzheimer's disease research grant. Because this insidious mind-destroying disease affects approximately 2½ million individuals each year in the United States and the costs are over $30 billion a year in trying to treat this, can the number of Alzheimer's patients be expected to grow and what can we do about it?

Dr. BRIDGERS. The reason why Alzheimer's disease is still in the research mode is this: We understand really precious little about this newly recognized entity. It's only through efforts such as those of Dr. Schnaper at the Center for Aging and other investigators that we quite possibly will soon get a handle on this problem, factoring out from other forms of dementia. And then, obviously, once we understand the cause perhaps we can approach a cure or a way to prevent it.

Senator SHELBY. Do you believe that the fear of long-term illness and its associated very expensive health care cost, in addition to the fear that there, you know, might be or will be a financial and emotional burden on their families, contributes to a lot of the suicide problems of older Americans?

Dr. BRIDGERS. We know that suicide in the elderly is associated with depression.

Senator SHELBY. Is it one of the higher ones in the United States?

Dr. BRIDGERS. Yes, sir. And we know that the financial problems and burdens can certainly lead to a situation of depression. So I would say they have to be in some way related.

Senator SHELBY. Dr. Bridgers, I know you're not a financial expert or analyst, but when we approach this legislation we need to try to bring about a comprehensive bill. We're going to have to fund it and we're going to have to pay for it some way. Do you have any thoughts on that?

I know that Medicare is inadequate for long-term health care. I believe that the proposal by the administration does not speak to a lot of the real issues that you have mentioned here today.

Dr. BRIDGERS. The major proposal to date by the administration, of course, is the very straightforward stop loss on existing Medicare coverage. (And their estimates on cost continue to rise slightly as new calculations are made by the CBO and others.) The last figure I have heard is some $6 plus a month as a mandatory add-on to the voluntary part B premium. As to the total cost, if we went so far as to include chronic care, I am simply not an expert on this topic.

Senator SHELBY. Do you have any numbers as to, approximately, how many Americans, elderly Americans, would have to have long-term extended care, such as in nursing homes, out of our population say of 240 million?

Dr. BRIDGERS. Of the 26 million people over 65, about 1.5 million reside in nursing homes. This increases with age: About 2 percent

of those 65–74 will be in such facilities, 7 percent of those 75–84, and 16 percent of those 85 or older.

I would like to make another point, one that I think is often misunderstood, and I had it in my written testimony and did not have time to mention it here: A lot of people "pooh pooh" the thought of having to spend down to cover a catastrophe within one's family, pointing out that there is a very small percentage of families each year who will experience such a catastrophic illness, such as a need for an organ transplant or some other disaster.

That's not the point. The point is, over a period of time, 5 years, 10 years what's the chances? And there are some estimates that as high as 1 in 3 families may be faced with such a catastrophe. And that's really the scenario that I think we need to focus on.

Senator SHELBY. You are familiar with the administration's proposal——

Dr. BRIDGERS. Yes, sir.

Senator SHELBY. Dealing basically with Medicare part B. As I understand it, and it was my concern, this doesn't address at all the long-term extended nursing home problem or the spend down that you just alluded to, does it?

Dr. BRIDGERS. It carefully avoids addressing that.

Senator SHELBY. Carefully avoids it. So a lot of people would probably be misled into thinking, again, that their bills will be taken care of if they pay $5 a month or whatever it is in addition to what they're paying now and that would not be true at all, would it?

Dr. BRIDGERS. I agree completely, that's right.

Senator SHELBY. It just seems to me Doctor, that with 240 million people there is some way financially for us to come up with the numbers, the right numbers, for all of us to pay a little to help a lot of people that will be victimized—through no fault of their own.

Dr. BRIDGERS. Even those of us who aren't yet at risk because we're not 65 or older, are nonethless at risk because we have family members and some day we'll all be there. And I couldn't agree more, that it's a burden the entire Nation should bear.

Senator SHELBY. Dr. Schnaper, the director of the Center for Aging at UAB, could not be here today, but we're going to leave the record open for any testimony or questions or statements that he also might want to include for this hearing. And I wish you would inform him of that.

Dr. BRIDGERS. I certainly will.

Senator SHELBY. Dr. Bridgers, we appreciate you being here. As I have indicated, I'll add your testimony to this hearing record and your concerns and let's keep working together to bring about a comprehensive health care package. Thank you very much.

Dr. BRIDGERS. Thank you, sir.

[At this point, Senator Shelby would like to make part of the hearing record the follow-up questions for Dr. Bridgers and his submitted responses.]

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FOLLOW-UP QUESTIONS FOR DR. BRIDGERS

Senator Shelby: It is my understanding that only one-third of those potentially at risk for nursing home care now reside in a nursing home--the remainder are cared for at home, frequently by their families. In my mind, these families deserve credit and support. However, one criticism of expanding Medicare to include coverage of long-term care (including nursing home care and home- and community-based care) is that federal support in this area would produce a disincentive for families to care for individuals capable of remaining in the home.

Although there is some research in this area which disputes this argument, have you found this to be the case?

Dr. Bridgers: The same studies that suggest that there are people in community settings who could or should be in nursing homes also suggest the converse: there may be about the same proportion in nursing homes who could be in community settings. Thus, any changes in policy on reimbursement for long term care in any one setting would most probably have impact upon all others.

Senator, the key to a meaningful answer to your question is the term you wisely chose, of being potentially at risk, and this must be coupled with risk for long stays in nursing homes, not just a few days

of convalescence now and then. The overwhelming majority of the elderly reside in the community; only about 5 percent are institutionalized at any one time. It is indeed true that a goodly number of the noninstitutionalized receive care from community based caregivers or from family members. However, research on these alternative sources of care shows that few who use home- and community-based long term care services would have been long-stayers in nursing homes. The long stayers are older, sicker, more dependent and poorer in social resources. (The latter factor, of course is wherein lies one major concern, as I discussed in my testimony.) Thus, it is unlikely that adding Medicare benefits for community or home-based services will significantly reduce total nursing home costs. Home and community care benefits would allow increased care in settings other than nursing homes, but these should be understood to be add-ons, not replacements for nursing home care.

Whether a proposal to cover home- and/or community-based care would discourage or encourage families from caring for their elderly parents would depend upon the specifics of the program. A system that paid professional providers for such care, but did not offer compensation to family member caregivers, might indeed have the effect of reducing family willingness to provide care. By contrast, a program that allows payments to family members would almost certainly encourage family care. In some ways such a system already exists: it is not uncommon for mom to move in with daughter's family, contribute her Social Security to the family resources, and allow the family to claim her as a tax deduction. Providing more resources for family caregiving would strongly encourage many healthy elderly to live with their

children. In my view this may be good social policy, but it will be expensive if further subsidized.

It is difficult to design research that would address all of these complex trade-offs; however, until our insights are clearer, I would be inclined to be cautious in proposing any major changes in coverage. The problem demanding attention first is the inadequacy of payment systems for needed nursing home care for those requiring extended stays, and this is where I recommend the main attention be devoted.

Senator Shelby: In your prepared testimony, Dr. Bridgers, you mentioned the importance of adding a prevention component to the Medicare program and convincingly argue that the long-term cost savings would justify the initial relatively substantial investment. I am very interested in this suggestion and compare it to the importance of investing in biomedical research, (which down-the-road has the potential to to save millions of dollars when scientists find cures and treatments for diseases).

The idea of investing in preventive measures has been repeatedly suggested by knowledgeable people such as you. Why do you think policy-makers have hesitated in the past and, for the most part, continue to hesitate to invest in this area?

Dr. Bridgers: Senator, I have pondered this question more than any other single health policy issue, and I believe the reluctance is primarily related to the abstract nature of the primacy of prevention. When we claim that a disease or dependency state has been or could be

prevented in groups at risk, one must always wonder: how do I know that I wouldn't have avoided that condition even if some measure hadn't been taken to prevent it? This uncertainty, coupled with the reality that, if a preventive measure is successful, nothing happens--there's been a non-event, if you will--leaves people with an uncertainty about what they're paying for when they purchase prevention. Contrast this with the critically ill person with the need for, say, a new set of coronary arteries, and the outcome of the policy-making process is understandable: treatment gets the nod and prevention gets ignored.

But there is a certain unassailable logic which shows that this is a short sighted way to view the evolution of a balanced health policy. The bottom line is hidden in the meaning of the terms incidence and prevalence, and I am afraid those of us fostering prevention have done a poor job of pointing out the fundamental difference between the two. The incidence rate is the number of <u>new</u> cases that develop in, say, a year. Prevalence is a measure of the <u>total</u> cases present at any point in time. Therefore, these two terms are related by the length of time that a disease may last: prevalence is the product of incidence and duration. Treatment strategies deal with new (incident) cases as they occur; however, treatment by definition can do nothing to reduce the incidence--the next cases will occur right on schedule. Treatment, therefore, can reduce the prevalence of a disease only by shortening its duration. Prevention, in sharp contrast, reduces prevalence by reducing incidence. The unassailable logic is that, when it is possible to do so, prevention is the strategy that can reduce the number of cases that prevail: if the case is prevented, the duration is zero. It follows that, when it is possible to prevent, one has achieved the

ultimate in cost-containment: no disease, no treatment required, no associated dependency costs; and this can be accomplished through inexpensive, "low-tech" risk assessment and preventive measures.

Stated another way in more familiar terms, because the total costs for the health care system are the product of the price per episode and the number of episodes, we might want to devote a little more attention to strategies that can reduce the number of episodes of illness, because we've not made much progress trying to reduce the prices (and some analysts would argue we can't). On the top of the list of ways to reduce the number of needed episodes of care is prevention. At least, it's a strategy we haven't tested as fully as we might.

Senator Shelby: There is no question that any changes in Medicare coverage will be limited, and understandably so, by our federal deficit. Understanding this, but also knowing there are great health care needs that simply are not being met can be extremely frustrating for those of us in the Congress. If we switched places for today and you had to prioritize the need for nursing home coverage, the need for more liberal home health benefits, the need for investment in preventive health care services, the need for better catastrophic protection for the elderly person who suffers a major catastrophic acute disease, the need for more non-medical caregiving services, the need for better coverage of prescription drug costs, and the many other unmet needs of our elderly and non-elderly population, where would your priorities fall?

Dr. Bridgers: Senator, you have posed an extraordinarily complex question, and my response will, I am afraid, not be entirely satisfying to you, myself, or anyone. Even in medical care it is impossible to do everything for everybody. Further, because everyone has different health problems, the mix of insured services that might be right for one individual may be of only limited help to another. It is my view, however, that people--including the elderly--are, by and large, able to make appropriate decisions about what is best for them, and this ability extends to which health services they require. The problem, of course, is that the wherewithal to purchase such insurance or even its availability if one does have the resources to purchase it is presently inadequate, disjointed, or for some services nonexistent.

Senator, I first tried to analyze your question on priorities by taking into account the several factors that must enter into one's judgment call. These include: (a) the size of the problem; how many people would it affect? (b) The urgency of the problem if left unaddressed; (c) the severity; is it life-threatening? (d) the effect upon others, such as family members; (e) the cost of correcting the problem; (f) the effectiveness, including the short-term and long-term payoff from correcting the problem. This analytical approach might show that, for example, home health care would get the highest "score" (affects a significant portion of the elderly but not all; is presently inadequately covered but not especially expensive; is, however, not usually dealing with an urgent health matter; is, for its purpose, probably effective). But is it reasonable to try to sum up these factors and arrive at a priority? Probably not, unless one is comfortable adding apples and oranges. Is it reasonable to attempt to

quantitate parameters which are, in some cases, qualitative issues (such as "urgency")? Thus, after giving this matter of scoring and setting a rank-order of priorities some considerable thought, I have decided that we should arrive at our judgments on a less rigorous basis and ask a simpler question: would addressing any given issue (say, home health care, catastrophic coverage, preventive services) be a reasonable thing to do at this time, given our state of knowledge, our financial constraints and the political support for it, both within the Congress and from those citizens to be affected? and how many such initiatives can be address?

One tempting recommendation would be a sweeping and broad system of capitation that would allow individuals the flexibility to choose from a wide range of insured coverages, including catastrophic, long term, drugs, and all the rest. The hard policy question, given this option, would then be how much can we as a society afford to put in the kitty for each elderly person? In the light of all our other needs (i.e., the tradeoffs between social or domestic and defense programs, retiring the debt, etc.) the issue is one on which reasonable people may disagree, and it would be very difficult to arrive at a reliable cost estimate before the fact. Stating the solution in this way also begs the question of whether a pervasive system of capitation would be popular with the majority of the elderly and providers. I am not certain it would be. Additionally, because it is not at all clear that a capitated scheme will become the predominant organizational arrangement for the non-elderly, would we then be at risk of ending up with a type of schizophrenia in the system: one scheme for those under 65, and another when one becomes Medicare eligible? At this time, I believe

that this could be the result if care for the elderly were completely cpaitated. Thus, until it is clearer whether the hopes of some, (that a capitated scheme will become the pervasive form of organization throughout the system) will be realized in the near future, which I very much doubt, or continue to be frustrated, which seems far more likely, I don't believe that a proposal to globally capitate health care needs for the elderly can be defended (albeit its limited use for those who prefer it shouldn't be discouraged).

I will therefore address your question on priorities in a different way, bearing in mind your caveat that any changes in Medicare coverage must be limited (as long as the federal deficit looms so large). I will state my preferences in order. As a first priority I must urge adoption of risk assessment and forecasting coupled with simple, mostly non-medical, preventive interventions. In keeping with our tradition of incremental changes, in my testimony I suggested that we commence this heightened awareness of the power of prevention by establishing a Commission for Preventive Services and by a program of "entrance exams" for new Medicare beneficiaries. My reason for selecting this as a top priority is that until we vigorously pursue programs to prevent catastrophic episodes they will continue to occur on schedule and at ever-increasing costs. All the other possible new coverages, important though they may be, are addressing problems created because the horse has already left the barn.

After preventive services, my pricrity would be to offer coverage for catastrophic care, using the Bowen definition, as I noted in my testimony. I deliberately choose this definition because, if literally interpreted, it would include not only the high tech, high cost

interventions for serious, acute diseases but also extended nursing home care for many indigent or potentially medically indigent people--let's call them low-tech catastrophes as opposed to what we usually think about, but catastrophes nonetheless. If catastrophic expense is defined as that which exceeds 15 per cent of income, about a quarter of the elderly are at risk each year for such acute care services alone, and if long-term nursing home expenses are included, which they should be, those at risk are many more. I do want to point out, in addition, that using this definition, outpatient prescription drugs expenses are included as among the items that would be included for those most in need. Further, for those with very low incomes the Bowen proposal on a $2,000 stop-loss would greatly exceed the more reasonable cut-off of 15 per cent of income, and I therefore favor the latter approach.

I am aware that placing catastrophic coverage in a higher priority than, say, explicit provisions for prescription drugs for all Medicare beneficiaries, may not presently have as pervasive a base of public support; it can be argued that not as many people would benefit as soon. But those who would require catastrophic coverage are among the most critically in need of relief, and all would benefit by the peace of mind that they're now protected. These two, then, Senator, are, to my way of thinking, the most important (for the near term) as Medicare amendments deserving prompt action: a coupling of coverage for catastrophes with a program to reduce their incidences via prevention.

Senator Shelby: I believe that you and I both agree that there is an urgent need to place more emphasis on the study of geriatrics and

training in this specialty. What incentives can you suggest that would help attract talented individuals into this field? And further educate the public about its importance?

Dr. Bridgers: It is well known that the elderly now consume a disporportionate amount of the nation's health care resources, as shown by the elderly constituting about 11 per cent of the U.S. population (slightly higher in Alabama) yet consuming about 30 per cent of the total health dollar. Two-thirds of this expenditure is from public funds. With the increased competition, both by individual health care providers and institutions, for the patient dollar it is apparent that the elderly offer a source of income. It is anticipated that there will be an increased direct recruitment of the elderly patient by providers. Coincident with this activity is the increased sophistication of the elderly population as to their expectancies for health care services. This "education" has come about as a result of many activities: participation in informational programs such as those offered by the Area Agencies on Aging, and influence of younger family members and acquaintances who are knowledgeable about geriatric resources. It is expected that future patient populations will be even more knowledgeable and more selective as to providers of geriatric care.

It can be expected that in the near future we will see an acceleration of publicity about individuals who have special geriatric training because of their obvious value to the elderly. Thus, to answer your question, the market itself will provide the major incentives for doctors to seek such training and indeed, those completing quality geriatric programs are already in great demand.

The issue of how to educate the public is a fairly easy one to address. The Geriatric Education Center here in UAB's Center for Aging are major resources with access to the membership of professional associations representing almost all disciplines in the Medical Center, with newsletters that circulate throughout Alabama, and with a growing network of individuals located throughout the state who have participated in our training programs. We have access to thousands of elderly through our cooperative relationship with Area Agencies on Aging, through the identification of rosters of elderly who have been screened through our research programs, and through cooperative relationships with the media (TV, radio, newspapers). I do not know how regions of the country without such resources can go about educating the public, but if they are not already tapping into the GEC's they should.

Senator Shelby: The Institute of Medicine (IOM) will soon publish a study on the need for geriatric leadership in the United States. We understand that among the study's recommendations is a suggestion that comprehensive geriatric research and training centers should be established. In your opinion, would such centers be a suitable vehicle for addressing the country's geriatric leadership needs?

Dr. Bridgers: A major resource to the geriatric field is currently available and in place, with 22 geriatric education centers (GEC) located throughout the country. This program must be one of the best bargains with the biggest "bang for the buck" of any federal program currently active. The Bureau of Health Professions spends about 12

million annually across all centers and gains from this modest sum numerous effective programs including development of geriatric curricula, many of which are quite excellent. These curricula include: marketing strategies that publicize geriatrics; development of resources, such as trained faculty, library holdings, etc. The GEC programs must be reauthorized the next year as part of the bureau's reauthorization. Specific language supporting the GEC programs will go far towards meeting the geriatric manpower's needs our country faces.

The question becomes one of whether it is best to expand the GEC to include research (which could be accomplished in our situation at UAB very easily), or should centers of excellence in geriatrics be created as new entities. The creation of separate entities with different goals makes no economic or programmatic sense to me. The history and current status of geriatrics at UAB leads me to believe our best chance for further progress lies in making the GEC a central player in expanding geriatric activities and incorporating with these centers the clinical geriatric research activities.

Senator Shelby: Have you conducted any longitudinal studies on the elderly and the process of aging--specifically: How they cope with the whole idea of being or getting old? What their outlooks are for their elderly years? What they fear: health, income, isolation, dependence/loss of independence, loss of spouse, loneliness?

In association with the Alabama Commission on Aging, our center at UAB under the leadership of Dr. Glenn Hughes recently completed a needs survey of Alabama's elderly by interviewing over 1,000 elderly

selected in such a way that they represent the elderly population in Alabama. This survey was designed to evaluate the needs status of Alabama's elderly in order to produce a policy document that will be available to legislatures, agency heads, etc. The data will allow statements on the elderly's coping success, quality of life by an algorithum to be developed, and identification of specific deficit areas. As soon as the analysis is completed I would be happy to share their findings with you. In addition to our data there are several existing reports that describe the elderly's coping success and identifies the areas they fear most; most surveys identify health as number one, with income number two, in regards to areas of importance.

Senator SHELBY. We have a panel that was supposed to testify, a Mr. and Mrs. Jim Turner, and I understand they have had to take someone to the hospital and they may be unable to attend.

Ms. PRIMROSE. They have just come in.

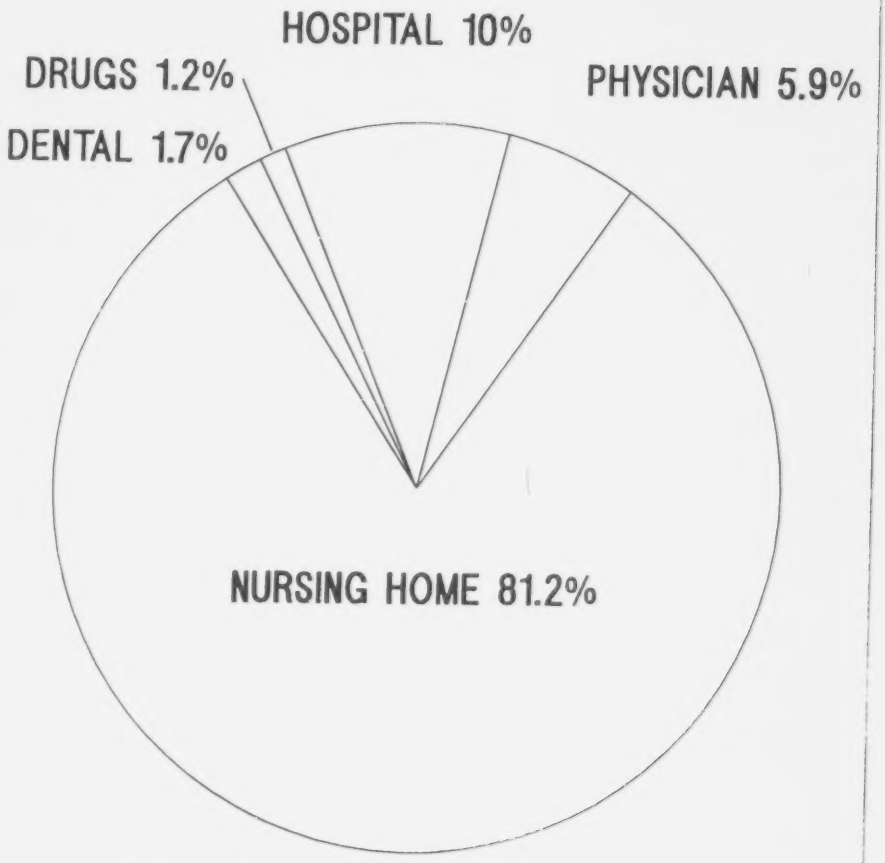
Senator SHELBY. They're here now. Well, that is good. If they can come on up to the table, we would appreciate that.

Are you situated okay, yes?

Mr. TURNER. Yes, sir.

Senator SHELBY. While we are waiting for the second panel, I want to state that the chart on my right here that you're facing, most of you can see, except the people in the jury box over here on the extreme right, is a graph. This graph shows the breakdown of the out-of-pocket costs for the elderly in excess of $2,000. As it is clear from the abundance of the bright red color there, the nursing home section at 81.2 percent, is clearly the largest piece of the pie, if you want to describe it as a pie.

Medical Expenses of Elderly With Over $2000 in Annual out-of-pocket costs



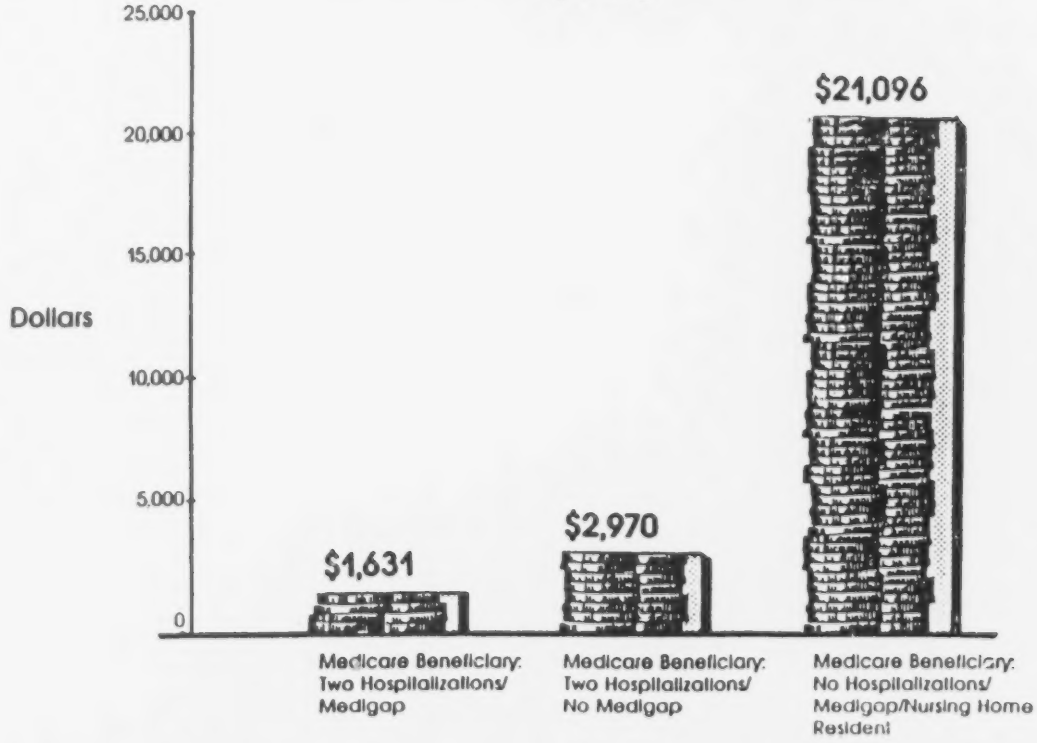
Source: Rice and Gabel, *Health Affairs*, Fall, 1986

Well, what does this really mean? Well, above and beyond the substantial sum of $2,000 shown there in medical cost, the majority of the health care cost for the elderly goes for nursing home care. Obviously, there is a pressing need to include long-term care in any legislative proposal and a need to re-evaluate, I believe, the out-of-pocket expenses caps in the proposals that are currently before the U.S. Congress.

The graph on my left, that I hope you can see, displays the dollar and cents aspect of catastrophic illness. It's certainly an integral part of it. The chart on the left indicates the annual out-of-pocket medical expenses for a Medicare beneficiary. We can see that the Medicare beneficiary, who has medigap insurance, has medical expenses of $21,096 for just 1 year of nursing home care.

CHART 2

ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



Source: Based on Congressional Budget Office preliminary estimates.

Under the Reagan administration's proposal, this Medicare beneficiary that I am referring to over here, who has a medigap policy, is still paying $21,096 on nursing home care in 1 year.

In other words the administration's proposal does nothing to ease the financial burden of this truly catastrophic case, it doesn't even approach it. If the Medicare beneficiary we have been talking about here could not afford this amount, then, under the present system that we have, he or she would be forced to spend down everything they have including their home, just like Dr. Bridgers testified here to. They would have to spend their life savings, if any, before becoming eligible for Medicaid assistance for nursing home care. They would have to be almost penniless.

I don't believe that we should allow catastrophic illness to penalize the elderly for a lifetime of hard work and saving in this country. I don't believe that we should take away the financial and the psychological independence of any couple or any family when one member becomes seriously ill. We should never allow a catastrophic illness to dictate poverty to any American.

I wanted to point these charts out for you because they graphically show some things that are hard to articulate otherwise.

Our second panel will help us turn away here from the many compelling statistics that I just mentioned and focus in on the human aspect of the catastrophic health care cost issue. We will learn about the hardships that our friends and our neighbors and our families have tried to overcome. It's very likely that everyone in this room today, either has a personal experience with or knows someone who has had similar difficulties. In preparation for this field hearing today, we came across a number of very distressing stories which rather graphically illustrated the many problems surrounding the issue that we have been trying to talk about.

They range from a proud Southern woman nearing her 70th birthday, who while caring for her 92-year-old mother has watched her mother's life savings of over $150,000 be spent and exhausted on health care, to an 81-year-old man who called my Birmingham office yesterday who has been forced to sell his home and spend much of his family's life savings to pay for the care of his wife, afflicted with Alzheimer's disease.

Of course—because of their caregiving responsibilities and their own personal physical problems, these people, I believe, are heroes. And there are other victims out there, many that could not be here with us today. We're fortunate, however, to have some witnesses who have found time, and who have taken time from their schedule, to share their personal catastrophic health care stories with us today.

We have Mr. and Mrs. Jim Turner. I want to welcome you to this Senate hearing. Any written testimony that you have or will have regarding your concerns and thoughts will be made a part of the record. The record, as I said earlier, will be left open until April 30.

If you would—either one of you that wants to start, I won't choose—relate to me for the benefit of the people here, your concerns.

Mr. TURNER. Senator, we thank you very much for allowing us to attend this panel. If I may, I would like to speak for my wife who

has been awake all night at the hospital attending her father who was admitted on an emergency basis yesterday.

Senator SHELBY. You go right ahead.

STATEMENT OF MR. AND MRS. JIM TURNER, PLEASANT GROVE, AL

Mr. TURNER. I'm Jim Turner, my wife is Jerry and we're very glad to be able to present this to you this morning. This is very, very important to us.

My mother-in-law is Sadie Gray, she is 73 years of age. She is presently in a nursing home and she is afflicted with Alzheimer's disease. My father-in-law is 78-years old, he is an invalid, he requires care at home. My wife has five brothers and three sisters. She is the one that is responsible for handling the entire problem that we're now facing. At this time there are family problems, which I will not go into, but these things do have a tendency to cause the family to pull apart simply because none of us can agree on what we think should be done, especially, from a financial standpoint.

My father-in-law and my mother-in-law had, approximately, $14,000 in their savings account. And I would like for you to keep in mind their age at this time, they're both well above 70 and $14,000 is nothing, but that's all they had, that was their entire savings and this is gone and was gone in no time at all. Once we finally had my mother-in-law approved by Medicaid to be paid at the nursing home, the entire resources had been spent down to less than $800.

We understand right now, that even though she was approved in October, that medically, that none of the funds have been paid. I would like to say, that the nursing home that we have her in has been very, very helpful to us. Although they have not received any of their money, they are not sending us any bills and that's a great help from that standpoint.

We have other things that we have to pay for such as laundry services, a few prescription drugs that are not covered, every day personal items that—they're just not covered at all. My mother-in-law's Social Security check is only $251 and most of that goes toward the nursing home anyway. So you can see there, there is nothing left.

My father-in-law receives, approximately, $500 a month from his Social Security. He does live at home, the home is paid for. However, we have power bills, phone bills, gas bills, we have groceries, we have to pay an individual to come in and stay with him on a daily basis. Now, he does not require around-the-clock service, but he does require someone to come in and help him everyday, as far as his meals and so forth go.

We have considered putting Mr. Gray in a nursing home also, but what we failed to mention in our letter, Senator, is this, we've just found out that if we put Mr. Gray in a nursing home that Mrs. Gray would be removed from Medicaid. And we just found this out and this was told to us by the folks in Montgomery. We had such a hard time having her approved in the first place, that we're very reluctant now to enroll Mr. Gray for fear of taking her off. We

have also been told that if we have to sell the home that that resource or those resources will have to go strictly for medical care until it's spent down, there again, to $1,500. And then we have to re-apply to have Mrs. Gray put back on Medicaid.

Senator SHELBY. We appreciate your coming here today and sharing your personal experience which could happen to any of us and all of us. You found out firsthand that Medicare doesn't cover very many things, have you not?

Mr. TURNER. That's correct.

Senator SHELBY. And you have also found out that there is no blanket out there, safety blanket, in between Medicare, what they pay, what your hospital insurance will pay, and then trying to get down to Medicaid itself. In other words, if you qualify for Medicaid you have just about got to be down to zero, have you not?

Mr. TURNER. Yes, sir.

Senator SHELBY. So you're in a catch-22 situation there with both of the people, are you not?

Mr. TURNER. Yes, we are.

Senator SHELBY. Am I right in saying, that the medical expenses for both your father and mother cost over $45,000 to date?

Mr. TURNER. Yes, sir.

Senator SHELBY. And there is no limit in sight, is it?

Mr. TURNER. No, sir, there is not.

Senator SHELBY. None in sight?

Mr. TURNER. No, sir.

Senator SHELBY. In addition to the care that you give your father in his home, what other care is he receiving? Is he receiving care from outside sources?

Mrs. TURNER. He has a housekeeper that stays with him during the week. I was hoping to find some type of nursing facility just to check on him.

Senator SHELBY. Community based care?

Mrs. TURNER. Right.

Senator SHELBY. Home care or something?

Mrs. TURNER. Just check his blood pressure.

Senator SHELBY. How old is he now?

Mrs. TURNER. He will be 78 next month.

Senator SHELBY. 78-years old. And up until rather recently, whatever recently means, were both your mother and father in fairly good health?

Mr. TURNER. Yes, sir, they were fine.

Senator SHELBY. Worked all their lives?

Mrs. TURNER. Yes, sir. Raised 9 children.

Senator SHELBY. Nine children?

Mr. TURNER. Yes.

Senator SHELBY. Financially, would it be more advantageous for you to keep your father in his home rather than a nursing home?

Mrs. TURNER. I can't answer that.

Senator SHELBY. Is that a hard question?

Mrs. TURNER. Financially, it would be better for him to stay at home, but for his care and for his protection, he needs to be in a nursing home.

Senator SHELBY. He has reached that point where he needs long-term care?

Mrs. TURNER. Yes. But he is a very brave person, he does not want—he wants to help in any way he can.

Senator SHELBY. But you get to the point that you can only do so much for yourself?

Mrs. TURNER. That's right.

Senator SHELBY. I'm going to—I have just had a note given to me by the lady who works with me on this. I wanted to inform you, that we're going to have our field office look into your father's and mother's eligibility for nursing home care. I don't know if there will be anything there, but we will try to continue to help.

Mrs. TURNER. Thank you.

Senator SHELBY. The legislation we're talking about, until it's comprehensive in nature, won't do a lot for you. That's why we're holding this hearing.

We appreciate you appearing here with us today and giving us your testimony.

Mrs. TURNER. Thank you for asking.

[The prepared statement of Mrs. Turner follows:]

Testimony

of

Mrs. Geraldine Turner

My name is Mrs. Geraldine Turner and I am glad to be able to present this testimony on behalf of my mother and father. My mother, who is 73 years old, is presently in a nursing home afflicted with Alzheimer's disease. My father who is 78 years old, is an invalid who requires in-home care which I and a housekeeper provide for him.

Even though I have 5 brothers and 3 sisters, I handle all the responsibilities of caring for my parents through a power of attorney. I must also note that this has placed a burden on my family relationship. At this time, two of my brothers will not speak to me and have accused me of doing away with the family savings. At this time we have spent the $14,000 that my family had saved, and when my father goes into the nursing home we will have to sell the family home with contents and car to the state. These resources together should be valued at approximately $40,000. Up to this time I feel that we have spent an excess of $40,000 on the medical needs of my parents.

Mother's care in the nursing home is provided for by medicaid with her social security check going toward paying for resources at the nursing home. Resources are laundrying and other basic services that are provided by the nursing home. Sadie's social security check is $251 per month.

Father's care is provided for by myself and a housekeeper who I pay $70 to $80 a week to care for him from his social security check. Ed is in very good mental condition, but he is an invalid.

I really hate to have to put him in a nursing home, but I don't have the resources to care for him and this may be the only way I can continue to provide for him. I feel that if he is placed in a nursing home with his mental condition, he will probably be much worse off being in this environment and it will pull him down considerably.

I feel that there should be more home health care available to the public. I don't have available to me a nurse that will visit maybe twice a month, just to provide some type of health check-up to my father. Before we placed mother in the nursing home, home health care made one visit and did not return.

I feel that there should be some way for some agency to exist to inform people what to do when this problem is encountered. If it wasn't for the doctors, I would have not known what to do or how to go about trying to get Sadie in the nursing home. As it is now, there are no funds to pay for clothes, dental work, or eye check-ups. I have bills that I must pay out of my pockets. There should be some type of supplemental income to pay for these needs. At the present time, I feel that there is no one to take up for the elderly people. They are older and have a lot of pride in themselves, and they will not ask for assistance, often doing without a lot of basic needs. My father, Ed Gray receives $545 per month from social security.

Senator SHELBY. Mrs. Fuller, we also appreciate you coming to the hearing today and accepting our invitation to testify. I know that you have faced a very difficult crisis in your life over the past few months.

It's my understanding, and you correct the record here, that on January 19 of this year your 48-year-old husband suffered a massive heart attack which has left him severely incapacitated.

Mrs. FULLER. Yes, sir.

Senator SHELBY. In the months since then, you have found out firsthand about the devastation of catastrophic illness, what it will do for you, what it will do to destroy what little money that families accumulate.

Mrs. FULLER. Yes, sir.

Senator SHELBY. I would like to hear from you for the record. Any written testimony that you might have will be made a part of the field hearing record for the U.S. Senate in it's entirety. And you just testify here to what you want us to hear.

STATEMENT OF KATHY FULLER, BIRMINGHAM, AL

Mrs. FULLER. OK. My name is Kathy Fuller. I'm married with two children, a girl, 16, who is physically handicapped and mentally retarded, and a boy who is 11.

On January 19, 1987, my husband Tommy, who is 48, suffered a massive heart attack resulting in severe brain damage because of the lack of oxygen to his brain.

Tommy was in the hospital for a total of 36 days costing around $50,000. My family and I were told that his prognosis of him ever coming out of this were very poor. After my husband had been in the hospital a few weeks, we were told by the hospital that we would have to find a nursing home for him because I would not be able to take care of him in my home.

The hospital social worker gave us a list of five nursing homes. We found one that we liked, but we're told that they were full. We found another one, but again, they were full. But the same company that owned them also owned another one who had a vacancy. We visited the nursing home and was told that they could take care of my husband.

At that time, we went back to the hospital social worker and were told that this was a good nursing home. And after she made a phone call to the nursing home we were told that they could, indeed, take care of my husband.

We transferred him on February 11, 1987, carrying the doctor's orders with us. And after we had been there a few hours, we were told by the nursing home administrator that they would not be able to take care of him because they were not informed by the hospital that he had an airway and they did not have the staff to take care of him. On the advice of his cardiologist he stayed overnight fearing that the trip back to the hospital would be to traumatic on him.

Tommy was transferred the next day back to the hospital. During the next few days we, again with the help of the hospital social worker, started looking for another nursing home. We were told by the social worker that all of the nursing homes in the Bir-

mingham area were either full or would not take Tommy because of his age and because he was a total care patient, with the exception of one. We were told that this was the only nursing home that would take my husband. When we toured the nursing home, we found that it was no better or no worse than the others that we had looked at. But we were told because Tommy was a total care patient, our cost per month would be $7,000. My husband does have some insurance that would cover a skilled nursing facility. He also has a ceiling amount on his insurance of $500,000 in his lifetime. We have been told by his doctor, with Tommy's condition, he could stay this way for a week, 5 years, or even 10 years. Being that he would need additional hospital care in the future and that $7,000 a month for a nursing home, it would not take long for his insurance to be depleted. We felt that this charge was unreasonable since all the other nursing homes we had looked at were going to charge us $1,500 to $2,000 a month. We did not want the insurance company to be charged unfairly and we did not want to use up all of his insurance.

Since then, with the help of ombudsman, my husband has been placed in a good nursing home getting excellent care at a reasonable price. This was my first experience with a nursing home. Neither I nor any other of my family or his family had any knowledge of nursing homes. It was bad enough on our family emotionally to have to suffer through the days of not knowing whether Tommy was going to live or die, but to have us or any other family go through what we went through just to see that our loved one got the best, reasonable and affordable care, was unjustified.

I thank you for the opportunity to tell mine and my family's story. I know there are a lot of people and families who have suffered in the same situation as ours. With the help of our Government, maybe, in the future, we can save another family from going through what we did in this very emotional time of our lives. Thank you very much.

Senator SHELBY. Mrs. Fuller, we appreciate that. I also want to acknowledge Mrs. Judy Cooley, who is seated there with you, Mrs. Fuller's sister-in-law, for coming and sharing with us. You have been involved in this too, as a part of the family.

Mrs. Fuller, you know that my field office staff is looking into your Social Security disability. We are certainly going to try to help you in that regard. And we have had pretty good luck in the past, we hope it goes this way, it sounds like a case of error.

Mrs. FULLER. Yes, sir.

Senator SHELBY. I have got several questions just for the record. Assuming that your husband had not been covered by his company's health plan, would you have been able to afford the amount and the quality of care that Mr. Fuller is now receiving?

Mrs. FULLER. No way. Not with two children.

Senator SHELBY. So you're fortunate to a point——

Mrs. FULLER. I am fortunate to the point that he does have some insurance.

Senator SHELBY. But to the best of your knowledge, if the insurance company does not extend your husband's stay at the nursing home facility, what other options are open or available to you?

Mrs. FULLER. There is really nothing because Tommy is too young for Medicare.

Senator SHELBY. He doesn't—he is not covered at all by Medicare?

Mrs. FULLER. No.

Senator SHELBY. I want to make that point. If your husband is covered by Social Security disability you're not covered by Medicare; is that right?

Mrs. FULLER. Right.

Senator SHELBY. And your husband, at 48 years of age, has suffered a massive crippling heart attack, he hasn't received Medicare or Medicaid assistance?

Mrs. FULLER. No.

Senator SHELBY. So there is a gap in the coverage—that's what we're trying to point out—regarding any possible catastrophic health coverage for the future.

Mrs. FULLER. Right.

Senator SHELBY. Mrs. Fuller, to the best of your knowledge, is the only option that you would have open would be to return—return home to your family and bring him home if the insurance didn't work?

Mrs. FULLER. Senator Shelby, I don't even know whether that could be done. He needs around-the-clock 24-hour care, 7 days a week. I do have two children, I do work, I do have to support them.

Senator SHELBY. Yes.

Mrs. FULLER. I would have to hire around-the-clock nurses.

Senator SHELBY. That would be prohibited, wouldn't it?

Mrs. FULLER. Yes. He is also on tube feeding, he needs skilled care. He has to be turned, he is on oxygen, and he has to be picked up and carried, moved.

Senator SHELBY. That would be hard for you to do then?

Mrs. FULLER. There would be no way that I could do it. We have thought about it, the thought did cross my mind. Nursing homes are not one of my better subjects, I know how he feels about nursing homes.

Senator SHELBY. But there comes a point though in time that we have to do what we have to do?

Mrs. FULLER. Right. I knew there could be no way that we could take him home.

Senator SHELBY. Well, we appreciate your coming here and participating, as I have said earlier in this field hearing for the U.S. Senate, and we will continue to work for you.

My reason to hold these hearings, as I said earlier, is to have input from the people of Alabama into the legislative process to show that there is a gap or a need for a comprehensive bill. And your testimony will certainly bear fruit in that direction. Thank you for appearing. We appreciate you too, Mrs. Cooley.

We have our next panel and we want you all to come up to the table, I'll call you one by one. This is a distinguished panel of people that are dealing with this issue all the time. I appreciate you all coming here.

Dr. George Layton, vice president—chairman of the State Legislative Committee, Alabama Association of Retired People.

Dr. Raymond Walter, National Association of Retired Federal Employees, he is the president.

Mrs. Amelia Heath, executive director, FOCUS on Senior Citizens.

Mrs. Barbara Bonfield, executive director of the Jefferson County Office of Senior Citizens.

If you people would come to the witness table, we have some people there that will help you get set up. I want all of you to give your oral statement. Any written testimony that you might have today or will have between now and April 30, will be put in the record in it's entirety and made part of this hearing. I welcome you here because all of you on this panel have had extensive experience. And I would guess, fairly, similar experience in advocating for the needs of the elderly in Alabama.

I have a series of questions that I would like to ask all of you. I hope you feel free here today to answer any or all of these questions.

What are the priorities of the members of your various organizations?

We would like—we would all love to reduce the catastrophic $2,000 cap proposed by the administration. Extend the long-term coverage and include prescription drugs. What can we really do?

What do you think a catastrophic health plan must include before it can really be called a catastrophic health insurance and so forth?

Those are some of the questions I hope you will address as you get into your testimony.

Who wants to go first? Dr. Layton?

STATEMENT OF DR. GEORGE L. LAYTON, VICE CHAIRMAN, ALABAMA STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. LAYTON. Thank you, Senator Shelby. First of all, I would like to express our appreciation to you for arranging to have these hearings in Alabama and welcome you back to Alabama and it's good to see you today.

Senator SHELBY. Thank you.

Dr. LAYTON. At the beginning, Senator Heflin mentioned about Winterboro?

Senator SHELBY. Yes, sir. Over in Talladega—near Talladega.

Dr. LAYTON. Yes, sir. That's almost home. I was principal of a high school there for a number of years and my youngest daughter was born there.

Senator SHELBY. That's a fine community. You know, Senator Heflin is going today, but anyone who has run for the U.S. Senate has been in just about every community four or five times in Alabama and the speaker here is no exception.

Dr. LAYTON. Right. Anyway, I started to go with him.

Senator SHELBY. I'm glad you didn't because we want you to testify first. We'll try to get a car for you to catch up with him.

Dr. LAYTON. Thank you, sir. Of course, my remarks today will be—have been prepared and a more comprehensive statement will be filed with our office.

Senator SHELBY. That will be made part of the record, in it's entirety, as I have already said.

Dr. LAYTON. Then my remarks here will be very brief. I will focus my remarks this morning on four areas of concern.

One, the major source of catastrophic cost for older Americans; two, acute care cost; three, the association's response to the Administration's catastrophic proposal; and four, the association's own recommendations.

The most critical need for a catastrophic protection for older Americans is help with the cost of long-term care. I believe that is what you were asking awhile ago.

Nursing home stay accounts for 80 percent. Your chart shows a little more than that, but about 80 percent of expense incurred by older Americans, which seems very high for out-of-pocket medical costs.

For most older Americans, acute care illness is less likely than long-term illness to result in the catastrophic burden. For Medicare coverage of acute care is by no means complete. Beneficiaries must pay deductibles and co-insurance for Medicare coverage services. And must bear the full weight of the cost of noncovered medical services and goods. About 70 percent enrolled have purchased private supplemental insurance protection for themselves for the gaps in Medicare coverage. But there is a great liability in coverage offered by such plans as we know. They seldom provide protection against the cost of prescription drugs or balance billing by doctors, dental, eye care, and nursing home care. Further, their cost in premiums may vary from high to low and all kinds of costs. It is reassuring to believe that the Medicaid Program will protect elderly people from catastrophic acute costs, but this is not the case. In 1986, only 27 percent of the elderly people with family income under $5,000 were covered by Medicaid.

Who among the elderly are the most vulnerable to acute care catastrophic cost? The answer must be in the 21 percent of Medicare beneficiaries whose insurance protection is not supplemented by medigap or Medicaid. These individuals tend to be very old and poor. Another group of particular concern is the 44 percent of poor Americans who feel compelled to buy medigap insurance, but who surely most forego day-to-day essentials in order to do so.

Certainly, Secretary Bowen's catastrophic proposal represents an important first step in the development of the vital range to protect beneficiaries from acute catastrophic cost. With this proposal, now the administration's proposal is a minimal one.

This $2,000 cap of co-insurance deductibles would hardly protect an elderly person on limited means from financial catastrophes.

Further, the payoff is not the protection for extended nursing home care, prescription drugs, balance billing by doctors and vision and hearing. The administration's proposal may strengthen Medicaid care, but is misleading as a catastrophic protection plan.

The Association advocates the development of a benefit improvement that incorporates the catastrophic cap, but it is more comprehensive than the administration's plan. Our proposal better balances the need for acute care protection with a need for a long-term care protection, and it also includes critical protection for long-term beneficiary.

The American Association's packet consists of three parts. Our acute care proposal includes, hospital deductible per year; the elimination of hospital co-insurance on a lifetime limit; 61 day and 90 day; a $1,000 cap on Medicare part B costs sharing; a prescription drug benefit; Medicaid improvements, which we view as inseparable from the gap.

For the transitional period, two, we recommend improvement in the skilled nursing facility benefit and the home benefit as well. And a new rested benefit, people like to have a little time off. Three, a long-term care component would include protection against impoverishment of the spouse, the husband and wife. And No. 2, extension of home and community base options, this would be options for the States. We recommend that if you mix over financial situations to support these proposals, which would improve the Medicaid and Medicare, to include catastrophic illness, one, would be to increase the tobacco tax on the Federal level. And then the extension of the health insurance coverage for Federal and State employees, which are not covered now as I understand it. And then an increase in part B which is the doctor part of the Medicare.

We appreciate this opportunity to present these proposals. And we're happy that you are working toward a solution to this social problem.

Senator SHELBY. Doctor, we appreciate your testimony here today.

[The prepared statement of Dr. Layton follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

"THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE"

Presented by

Dr. George L. Layton

before the

SENATE SPECIAL COMMITTEE ON AGING

Birmingham, Alabama

April 16, 1987

Thank you, Senator Shelby. On behalf of the more than 24 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the problem of catastrophic illness.

Before I begin, however, I would like to say that the Association is gratified by the current congressional and public interest in the problem of high cost illness and its impact on the citizens of this country. We believe that the public debate on catastrophic illness will lead to a more complete and more accurate understanding of the problem; the debate itself is, in our view, a critical step in the development of workable, appropriate solutions to a complex but hardly intractable social problem.

Let me say, at the outset, that the Association commends Senator Shelby and the members of this committee for your work towards the development of catastrophic health protection for the American public.

I will focus my remarks this morning on four areas: the major source of catastrophic costs for older Americans; the nature of the acute care catastrophic experience among older Americans; proposals by the Administration and Congress to address elements of the catastrophic problem; and finally, recommendations by

the Association, building in part upon the work of Secretary Bowen, and proposals emerging from the Senate and the House.

THE MAJOR SOURCE OF CATASTROPHIC COSTS FOR OLDER AMERICANS

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term, chronic illness. As Chart 1 indicates, nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year).

The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care--be it in an institution or in the home--are often enormous. Chart 2 shows the amount that an individual would pay for a 12-month stay in a nursing home and for modest medical expenses during that year. At more than $20,000 each year, few families could survive such expenses without severe financial hardship. Medicare and private insurance combined pay only a miniscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid, a means-tested welfare program. To qualify for Medicaid, one must

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either be poor or reduced to poverty in the process of trying to pay for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Fully one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of older couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse--usually the wife--destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

Personal care services of indefinite duration in the home are not covered at all by Medicare, and the amount and type of home care

services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; we estimate that, on average, for every $1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional $.50 to $1.00 for non-covered services and goods.

1. Deductible and Coinsurance Liability

Under Medicare Part A, beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care ($520 in 1987). They are also responsible for coinsurance for days 61 through 90 equal to one-fourth of the hospital deductible. For each lifetime reserve day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the Part A deductible, or $260 per day in 1987. While there is no deductible for skilled nursing facility (SNF) services, Medicare beneficiaries this year will pay $65 per day to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a

provided under Medicaid is extremely limited in most states. Even those who can afford to pay for home health and other in-home services face often insurmountable barriers in locating competent, trained personnel. As a result of both limited access to home care and the very high expense of nursing home care, many older persons live in fear of becoming a burden on their families, or being forced to enter a nursing home and spend their lifetime savings in order to pay for care.

THE ACUTE CARE CATASTROPHIC EXPERIENCE AMONG OLDER AMERICANS

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 2 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly $3000 without private supplemental insurance and would even result in expenses over $1600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered

hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a year, thereby triggering hospital coinsurance requirements.

In 1985, Medicare beneficiaries incurred $3.2 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 100% between 1980 and 1985. The largest portion of total Part A cost-sharing liability is attributable to the Part A hospital deductible.

Beneficiaries also share heavily in the cost of Medicare Part B services. Each beneficiary must meet a $75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular Part B service. (In addition, beneficiaries whose doctors do not accept assignment are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B represent a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Part A. In 1986, Medicare beneficiaries incurred $5.7 billion dollars in Part B coinsurance liability and $1.7 billion dollars in Part B deductible liability. The most striking rate of increase in physician-

related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980. Moreover, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits.

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services in a given year, 80% will incur liability from the use of physician services during the same period. Further only .5% of beneficiaries will trigger hospital coinsurance costs, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

2. Medical Services Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and goods which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits.

These acute care services include:

- Balance billing by physicians on non-assigned claims
- Dental services/products

- Optical services/products

- Hearing care services/products

- Routine physician examinations, influenza shots, Pap smears.

Out-of-pocket expenditures for these non-covered acute care services can be staggering: almost $3 billion for balance billing by physicians; more than $2.3 billion for dental care; and more than $1.4 billion for eye care.

3. Prescription Drugs

In addition, Medicare does not cover outpatient prescription drugs. Out-of-pocket expenditures for outpatient prescription drugs were more than $7 billion in 1986.

Older persons consume a disproportionately large percentage of prescription drug products. Although those 65 and older constitute about 12% of the U.S. population, they consume about 30% of the nation's prescription drugs.

Prices of prescription drugs began to skyrocket in 1981 and have far outpaced other items in the Consumer Price Index (CPI) every year since. For the period January 1981 - June 1985,

prescription prices rose 56%, compared to 23% for the overall CPI. In 1986, prescription prices were again the highest of all medical care components, increasing at a rate of 8.6% per year, compared to the overall rise in the CPI of 1.9%.

AARP surveyed its members in 1985 and again in 1986 concerning prescription drugs.

In both 1985 and 1986, about 62% of those over 65 said they were taking prescription drugs on a regular basis. Of those taking drugs regularly, about 45% said that they received some assistance paying for those drugs from insurance or other health coverage. This finding was also unchanged from 1985 to 1986.

A significant change occurred, however, in the percentage of people age 65+ paying more for prescription drugs who get no assistance. The number of people who paid more than $41 a month, or over $492 a year, increased by 42 per cent in one year (i.e. 10 percentage points).

4. Home Health Care

Because patients are now discharged earlier from hospitals, home health care is an important component in continuing needed care.

By most measures, home health use has grown greatly. But, the

rate of increase in home health expenditures has moderated sharply in the past few years and has not matched previous and expected rates of growth. This fact is puzzling in light of reductions in the average length of hospital stay, the aging of our population, and previous growth rates.

One possible explanation for declining growth rates in home health outlays is that the Health Care Financing Administration (HCFA) is reducing access to this benefit by means of claim denials and the application of vague eligibility criteria. There is some evidence that coverage decisions are arbitrary and capricious and the denial rate certainly varies greatly by geographic area.

HCFA has failed to sponsor careful studies of the impact of prospective payment for hospital care on the need for and use of post-acute care services. Consequently, it is difficult to assess the extent to which the home health services now being provided satisfy demand.

It is clear, however, that Medicare beneficiaries face serious problems in trying to take advantage of this benefit. First, home health care providers are not effectively regulated and quality control and consumer protections are weak or non-existent. The absence of outcome-oriented quality control measures is a significant weakness in the government's oversight

most offer coverage of the former. Finally, the plans may impose their own deductible of up to $200 per year for Part B coverage.

In spite of the Baucus amendment, there is great variability in the depth and scope of coverage provided by Medigap plans. Most Medigap plans provide little or no coverage of prescription drugs, balance billing by physicians, dental services, and extended nursing home care. Moreover, the Baucus amendment does not apply to employment and labor organization-related group insurance, conversions from group plans to individual policies, and policies in effect before July 1, 1982. Finally, some plans may be very costly relative to the benefit returned to the insured.

It should be noted that supplemental coverage through a Medigap plan is positively correlated with income and education. Yet almost half of elderly people with less than $5000 per year in family income purchase Medigap plans (see chart 3). Even if the coverage selected is modest, the premium payments for such plans must constitute a terrible drain on already meager resources.

Let me at this point clarify the Association's position on the ability of the private insurance industry to protect older Americans from the inadequacies of Medicare's coverage. The Association offers its members a Medicare supplemental insurance plan that fills many of the existing gaps in Medicare coverage.

We believe, however, that filling such gaps through the Medicare program is inherently the most efficient way to insure against acute care catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental insurance plans or make them unnecessary.

6. Medicaid's Role in Protecting Beneficiaries Against Acute Care Catastrophic Costs

It is reassuring to believe that the Medicaid program serves to protect elderly beneficiaries from potentially catastrophic acute care out-of-pocket expenditures. But this is not necessarily the case. The Congressional Budget Office (CBO) reports that in 1986 only 27% of elderly people with family incomes below $5000 were covered by Medicaid (see chart 3). How can this be? We have only to look to the variability in Medicaid's eligibility requirements across states for an answer. There exists no national mandatory income standard for Medicaid eligibility, no mandated coverage of the "medically needy", and no uniformity in eligibility for a Medicaid "buy-in" of Medicare Part B coverage.

7. The Vulnerable Elderly

Who among the elderly are most vulnerable to acute care catastrophic costs? Surely the answer must include those who are

not able to afford Medigap coverage, but who also do not qualify for Medicaid coverage. Such individuals tend to be frail, low-income, and uniquely vulnerable to the cumulative financial burden resulting from Medicare coinsurance and deductibles and from the costs of all non-covered services and goods. For nearly 21% of the elderly, Medicare represents the only source of protection (see chart 4).

A second group worthy of particular concern includes the poor/near poor who feel compelled to buy Medigap insurance but who can ill afford it. One can only surmize that such individuals must forego certain day-to-day essentials in order to purchase such protection (see chart 3).

THE ADMINISTRATION PROPOSAL

The Association is encouraged by the demonstrated interest of the Administration and the Congress in finding solutions to the problem of high cost illness for older Americans, although we are disappointed over the almost exclusive preoccupation with costs arising from acute care illness. The Administration proposal based on earlier recommendations of Secretary Bowen addresses only acute care costs, providing beneficiaries with unlimited hospital coverage subject to two deductibles each year and "capping" annual out-of-pocket expenditures for Medicare coinsurance and deductibles at $2000.

The Association recognizes that, through his recommendations to strengthen the Medicare program, Secretary Bowen took an important first step in the development of a viable plan to protect beneficiaries against acute care catastrophic costs. Nevertheless, it must also be recognized that the Secretary's catastrophic proposal -- now the Administration's catastrophic proposal -- is a minimal one. The $2000 cap on coinsurance and deductibles would hardly protect an elderly person of limited or even moderate means from financial catastrophe. Nor is it likely to persuade Medigap holders to drop their supplemental plans and self-insure for the first $2000 in coinsurance and deductibles.

Further, under the Administration plan, no out-of-pocket costs for the following services and products would count toward the annual cap: long-term nursing home care, out-patient prescription drugs, dental services, home health services, physical examinations, balance billing by "non-assigned" physicians, and optical supplies and services. The Administration plan may thus offer some improvement in Medicare's coverage, but it is misleading to suggest that it would provide older Americans with protection against catastrophic health care costs.

Secretary Bowen in developing his catastrophic proposal has given

a matter of critical social significance visibility and credibility. He deserves credit for animating discussion and debate on the full range of catastrophic illness issues. Catastrophic proposals developed in the Congress advance this critical exchange of diverse ideas and help us to refine the elements of a workable, comprehensive plan.

AARP'S CATASTROPHIC PACKAGE RECOMMENDATIONS

One of the dilemmas policymakers face in attempting to set a protective "cap" on catastrophic costs is pinpointing the appropriate level for such a cap. Set the cap high, and the benefit can be financed without great difficulty; but as is clear from chart 5, few are protected under such an arrangement. As one pushes the cap down, the protective scope of the cap expands but the cost rises proportionately. Severely restrict the elements of liability which count toward the cap, and the plan becomes more affordable; the danger in <u>this</u> arrangement, of course, is that beneficiaries may wrongly assume that their <u>total out-of-pocket liability</u> in a given year will not exceed the cap level. As they gradually come to realize that a full range of essential medical services and products do not even count toward the "catastrophic" cap, they are apt to feel disappointed, if not duped.

It is important, then, that any plan that lays claim to providing any level of catastrophic protection must identify and appropriately address actual sources of vulnerability. The Association believes that long-term care is the real source of catastrophic costs for older Americans, including middle-income older Americans. We also believe that while acute care costs-- for both coinsurance and deductibles as well as non-covered services and goods including prescription drugs-- can threaten the financial security of many older Americans, they are potentially devastating to low-income elderly.

Given these concerns, the Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than the Administration plan and that, in our opinion, better balances the need for acute care catastrophic protections with the need for long-term care catastrophic protections. It also includes critical protections for low-income Medicare beneficiaries.

We do not delude ourselves in advancing the following set of recommendations that we have solved the catastrophic problem for older Americans. We do believe that in many respects our proposals expand, refine, and improve upon the efforts of others who have also grappled with this complex issue. Our proposals represent an earnest attempt to fulfill the President's pledge to protect Americans against catastrophic health care costs.

The benefit structure of the Association's package can be divided into three pieces:

1. Acute Care

2. Transitional Care

3. Long-term Care

Under the acute care component, we propose the following:

- One hospital deductible per year;
- Elimination of hospital coinsurance;
- Elimination of lifetime limits on hospital care;
- A $1000 cap on Medicare Part B cost-sharing (i.e., deductibles and coinsurance);
- A prescription drug benefit with a $200 annual deductible and a copayment on each filled prescription;
- Improvement in the Medicaid program through the establishment of a uniform mandatory income standard for Medicaid eligibility, and expansion of

coverage through the Medicaid "buy-in" of Medicare Part B services. We view this element of the package as inseparable from the cap which, at $1000, is too high to adequately protect low-income beneficiaries.

Under the transitional care component, we recommend:

- Elimination of SNF coinsurance;
- Elimination of the three-day prior hospitalization requirement for SNF eligibility;
- An expanded home health care benefit;
- A respite benefit (carrying a 50% copayment) to provide assistance to caregivers.

Our long-term care component would include:

- Protection against spousal impoverishment including both income and liquid assets;
- Expansion of home and community-based services; and

- Exploration of the feasibility of capping out-of-pocket costs associated with long-term care.

FINANCING THE BENEFIT PACKAGE

The Association recognizes that, given a burgeoning federal deficit, the kind of improved benefit package we are recommending must be self-financed. Further, results of a recent AARP survey indicate a willingness among a majority of older people to pay increased premiums in return for significantly expanded benefits. Nevertheless, the full burden of the costs of the improved package we are advocating should not fall exclusively upon the elderly. To pay for the improvements we have described above, we propose using an assortment of financing sources, some targeted on improvements in the Medicare program and others targeted on Medicaid remedies. These potential revenue sources include:

Potential Revenue Source	Target	Estimated Yield
o Doubling of the tobacco tax	Medicaid	$2.9 billion (1988)
o Extension of HI coverage to state and local employees	Medicare	$1.3 billion(1988) $5.1 billion over 3 years
o Increase in the Part B Premium not to exceed an additional $10/month	Medicare	Up to $3.7 billion
		Total: $7.9 billion (1988)

The package we have proposed, would probably not represent a replacement for a typical Medigap plan. We believe, however, that responsible private insurers would respond with a corresponding offset (i.e. reduction) in Medigap premiums to match their reduction in risk exposure. Thus, the net additional cost in premiums to the 70% of Medicare beneficiaries carrying supplemental insurance could be minimal. As a complementary measure, our recommended Medicaid improvements would serve to protect those not currently covered by Medigap or Medicaid. The proposal offered by some members of Congress to finance a catastrophic plan by taxing the actuarial or imputed value of that portion of the Medicare benefit that is not paid for by the employee during working years or through the Part B premium

represents a radical departure from the financing mechanisms which presently support the Medicare program. While we encourage the exploration of innovative financing approaches to fund catastrophic protections, we are not convinced that a modest benefit package justifies the adoption of such a radical change in existing financing mechanisms. We believe that other financing options should be exhausted before we consider such an approach.

CONCLUSION

I would like to conclude my remarks this morning with two observations. First, we focus our attention here today on the plight of older Americans, many of whom struggle daily under the crushing weight of catastrophic medical costs. Initial action to address their plight is appropriate and, indeed, long overdue. But let us not forget the suffering of some 37 million Americans under the age of 65 who have neither public nor private health insurance and the 15 million who do not have adequate. Surely a nation as richly blessed as ours in material wealth, wisdom, and compassion can summon the resolve to correct this terrible and intolerable social wrong. For our part, we cannot in good conscience support filling the "gaps" in Medicare's coverage, while at the same time ignoring inadequacies in health insurance coverage for working Americans and our nation's children.

Finally, as we convene this morning, we do so with the realization that Congress is poised for action on catastrophic protections for older Americans. Whatever the outcome of this year's initiative on catastrophic illness, let us be scrupulously correct in characterizing to the American public what we have accomplished and, perhaps more importantly, what we have not accomplished in our efforts to come to grips with one of this country's most pressing social needs.

CHART I

OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)

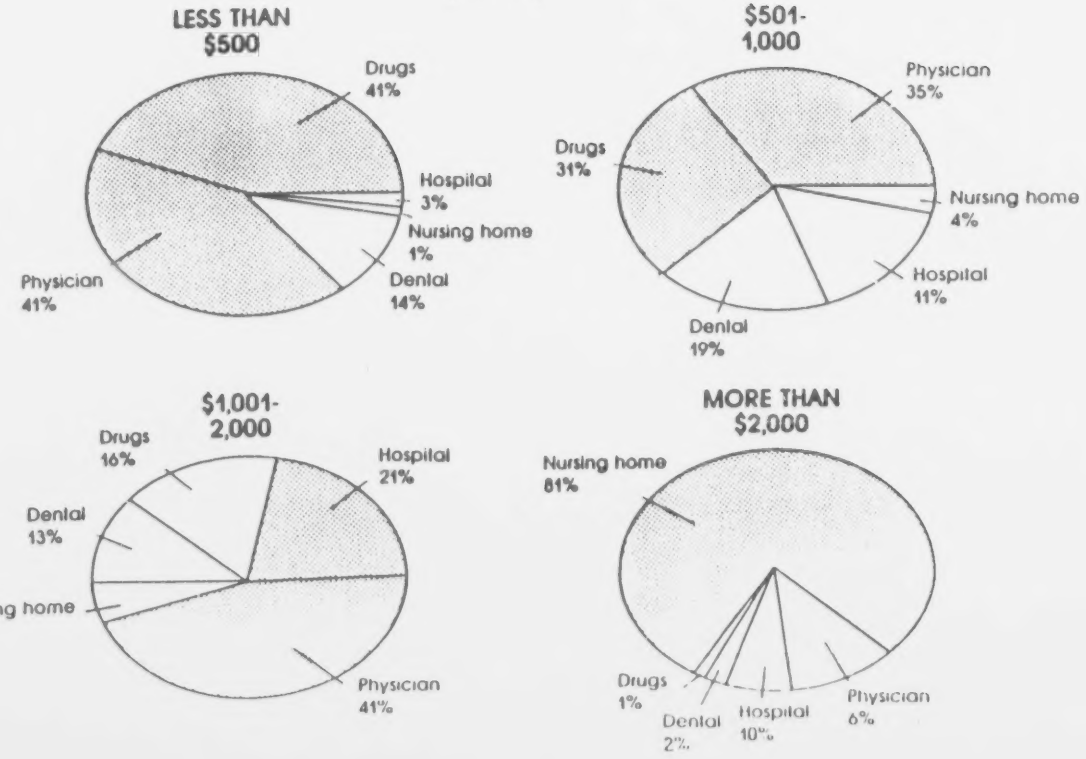
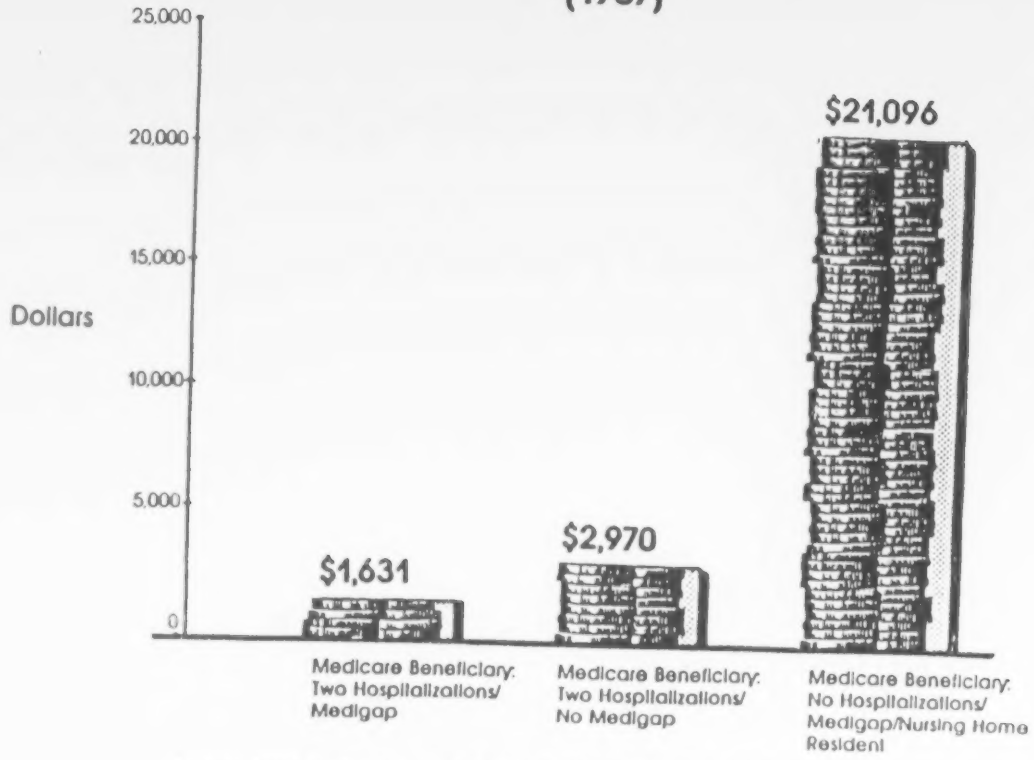


CHART 2

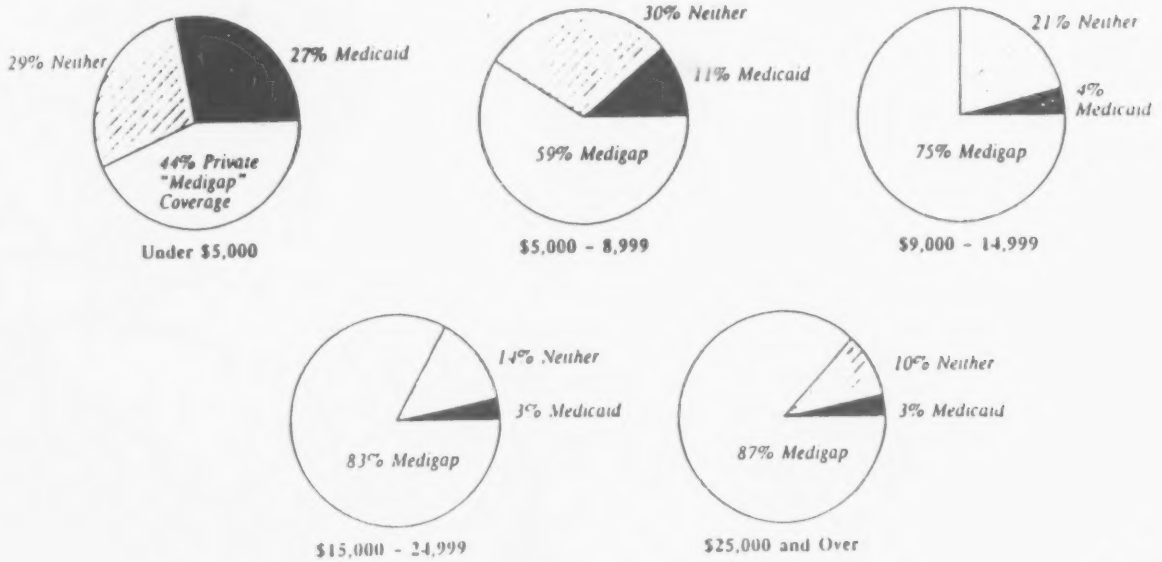
ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



Source: Based on Congressional Budget Office preliminary estimates.

CHART 3

MEDIGAP COVERAGE FOR THE ELDERLY POPULATION BY FAMILY INCOME, 1986



Source: Congressional Budget Office

CHART 4

ELDERLY POPULATION WITHOUT PRIVATE HEALTH INSURANCE OR MEDICAID

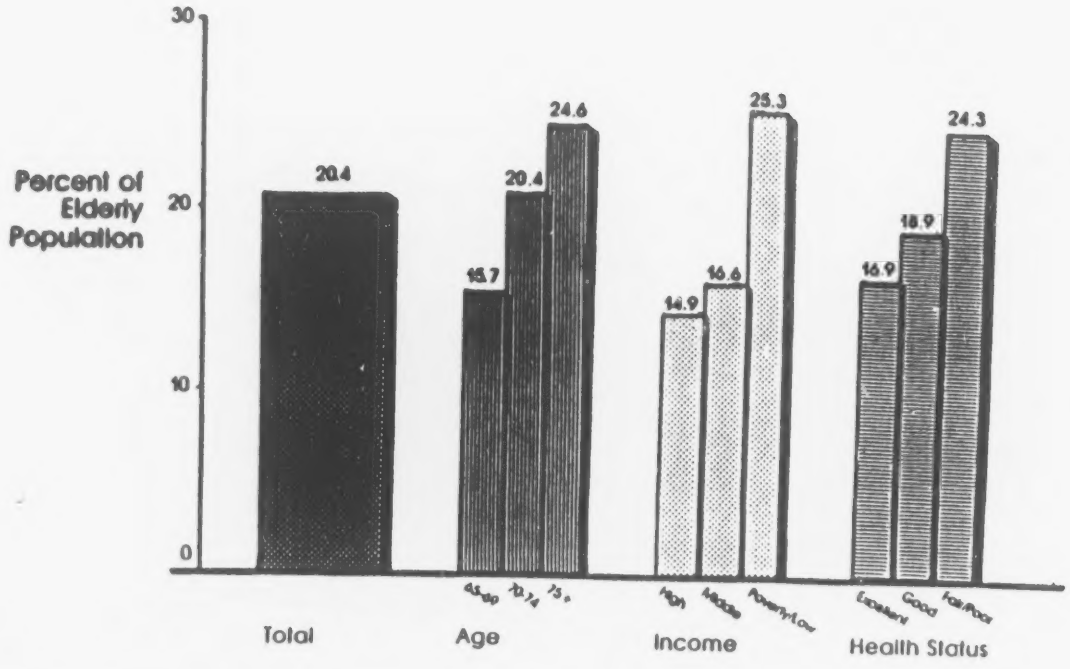
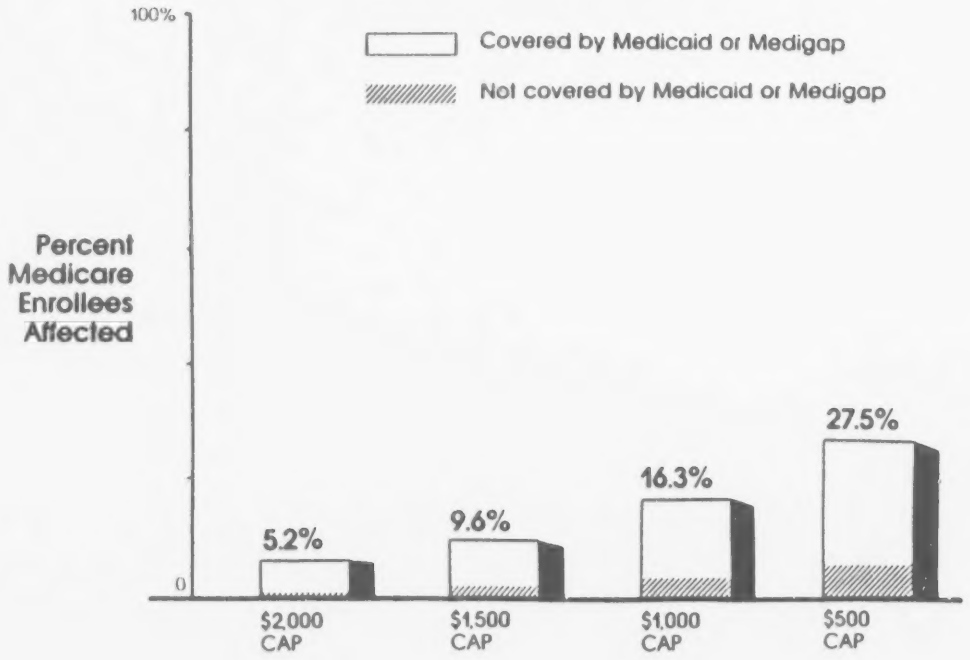


CHART 5

CATASTROPHIC CAPS: WHO BENEFITS? (1988)



Source: CBO estimates.

Dr. Raymond Walter.

STATEMENT OF DR. RAYMOND L. WALTER, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Dr. WALTER. Senator Shelby, this is a real good thing and I thank you very much on behalf of NARFE, the National Association of Retired Federal Employees. I will give you some specific instances of what we think are catastrophic health conditions that need some help.

We have here in Alabama, and since, as being president of this organization, I represent more than 10,000 people, most of whom are over 65, and many of them are really in need of financial help because of the illnesses that they are encountering. I have three different cases that I want to discuss with you. But since arriving here, I find the case of Mr. Holcomb here in Birmingham is extremely important and it contains some factors that I think also need to be considered. I will get this to you later on.

Senator SHELBY. We will keep the record open on that and I would appreciate that.

Dr. WALTER. The first case I have is one of Mr. Abner McGehee, who is a dairy farmer south of Montgomery. He and his wife have no children. He has been ill with Alzheimer's disease for the past 10 years. His wife has been taking care of him. He had to stop all farming and his farm is running down. So they have already lost a considerable amount of their estate. In the past 10 years, dairy farming, in that particular section of the State, has disappeared because of the cost of running it. So they can't even sell their farm. There is no one to buy it.

Mrs. McGehee is in good health, but is aging and is slowly showing the effects of the strain of caring for her husband. To help with the work, they hire a nurse for 4 hours a day, 7 days a week, at a cost of a $112 per week. Mr. McGehee must be fed through his nose and this costs $6 per hour. This is being done by a private nurse three times a day, 365 days a year.

Mr. McGehee stills pay the monthly premium for Medicare, which includes his wife, $35.80, and this comes out of Social Security. They have a $5 cost for catastrophic illness premium, but this does not provide enough for their remaining costs and they expect this cost to go up to $10 in the next year.

It now appears that Mrs. McGehee will outlive her husband. And since they have no children, they cannot dispose of the farm and Mrs. McGehee faces practically no means of support upon the death of her husband. This is the brief of one particular case.

The second case is the case of Mr. Allen McGee, no relation to the first and the names are spelled differently. He is 66 years old. In 1973 he had a severe life-threatening stroke and was left almost completely paralyzed. Allen and his wife have no children. Allen is a veteran with a disability occurring during World War II. In 1985, Allen's wife passed away leaving Allen almost completely helpless. Allen's brother and wife took care of him until about a year ago when it became necessary to place him in a nursing home for constant care. This was done with the advice of a physician. Allen was completely helpless. In addition to the stroke he has epilepsy.

Total cost of the nursing home at the present time is approximately $1,870 a month. This expense is not quite equal to his monthly income—because he has a Federal retirement. Incidentally, he does not have Social Security I need to point out, that many of the people whom I represent are over 65 and do not have Social Security. They have worked, given their lives solely to the Government and as such were not eligible for Social Security. There is little hope, however, Mr. McGee's income will ever increase unless the Federal Government adds to that. His only income is from his Federal retirement plus interest which comes from his wife's assets. While she was alive she made a will and the beneficiary of this will became her brother, but with the stipulation the interest be given over to the care of Allen.

So when Allen needed care, his brother, Jason, took him and cared for him, but they did not care for him all of the time. When the doctor said he had to go to the nursing home, that relieved some of the strain from Jason.

Allen and his wife owned a home. However, this home, without proper care, was badly in need of repair, and Allen's brother, Jason, paid for the renovation of the home. It is being rented out, but practically all of the rent has to go to maintaining it and keeping it in proper repair. This ends the second case.

The third case is a very, very sensitive one so far as the Millbrook-Prattville community and also part of Montgomery is concerned.

A Mrs. Ruff is 43-years old. She has emphysema. She was told last October that she had only 6 months to live. Six months are up, but she is still alive. Her doctor and the people in the Millbrook-Prattville community have helped her in many ways. Because of her husband's work causes him to travel, Mrs. Ruff stays with friends in Montgomery-Prattville and other places.

She weighs, at the present time, only 90 pounds. She is trying to get a double lung transplant. Five such transplants have been performed, three in England and two in Canada, none in the United States. In order to obtain a transplant, Mrs. Ruff must pay $20,000 which has been raised by the various churches in Prattville and the Montgomery, Millbrook areas. One contributor was the highway patrol people.

I need to say, Mr. Ruff is working and has to travel, but he has a moderate salary. I was not able to get the exact amount of his salary. They have two children, one in high school, one in college. The $20,000 was raised and given to the necessary people in Canada. Now, they're asking for $180,000, the total bill is $200,000. The likelihood of them raising this amount is very small.

So here is a case where catastrophic health care is needed immediate rather than long-term, this is an important factor. I think it's probably overriding so far as the need is concerned. This concludes my statement.

[The prepared statement of Dr. Walter follows:]

Three Cases Of Catastrophic Illness

By Raymond L. Walter, Ed. D. Alabama NARFE President

Mr. Chairman--Senator Shelby. I represent the National Association of Retired Federal Employees-NARFE for short. Many people in NARFE are concerned about their future. There are in Alabama over 9,000 NARFE members and the vast majority are over 65. Right now we have many who are concerned about Alzheimer's disease but there are a number of other ailments or disabilities which require much money on a monthly basis and providing this money is causing them to eventually become without any additional money to meet their expenses.

We have to think of castastrophic illness as both a short term, high cost situation as well as a long term, but still very expensive illness.

I have three cases which I want to discuss. Right now I am limited to cases I know about in the Montgaomery, Alabama area. However, on May 21 and 22 NARFE will hold a convention in Tuscaloosa and at that time I can and will canvass the entire state for more examples. Our examples are not limited to NARFE members, however.

1. Mr. Abner McGehee was a dairy farmer with no children. He has been ill with Alzheimer's Disease for the past 10 years. His wife has been taking care of him. He has had to stop all farming and his farm is running down so they have already lost considerable of their estate. While dairy farming was common in the area about 10 years ago there is none in the area today. They have tried to sell the farm but can get no one to buy it. Mrs. McGehee is still in good health but is aging and showing the effects of the strain of caring for her husband. To help with all the work they hire a nurse for four hours a day, seven days a week at a cost of $112 per week. Mr. McGehee must be fed through the nose, and this costs $6 per hour. This is being done by a private nurse. Mr. McGehee still pays a monthly premium for medicare of $35.80 out of his Social Security. This covers both Mr. and Mrs. McGehee.

   The $5 cost for a castastrophic illness premium does not provide enough return to cover the remaining costs. This is expected to go to $10 in the next year.

   It appears the wife will outlive Mr. McGehee. Since they have no children and they cannot dispose of the farm Mrs. McGehee faces practically no means of support upon the death of her husband.

2. Mr. Allen McGee is 66 years old. In 1973 he had a severe life threatening stroke and was left almost completely paralyzed. Allen and his wife had no children. Allen is a veteran with a disability occuring during WW II. In 1985 Allen's wife passed away leaving Allen almost completely helpless.

   Allen's brother and wife took care of him until about a year ago when it became necessary to place him in a nursing home for constant care. This was

done with the advice of a physician. Allen is completely helpless. In addition to the stroke Alan has epilipsy.

The total cost of the nursing home at the present time is approximately $1870 per month. This expense is not quite equal to his monthly income. However, the nursing home and related medical care costs are continually escalating. There is little hope, however, his income will increase. His only income is from his federal retirement plus some interest which comes from his wife's assets. His wife's "will" put her money with her brother but with the interest going to Allen.

Allen does not have social security and for some reason the V. A. hospital has terminated any further assistance. The information I have for the refusal is that Alan still owns a home which is badly in need of repair. No one will do the repair without payment and Alan does not have any money which can be used to repair the house. His brother paid for the rennovation out of his own income. However, the rental money is little more than enough to keep the house in living condition.

3. Mrs. Ruff, a 43 year old lady with emphysema, was told last October she has only six months to live. Her doctor and people in the Millbrook/Prattville community have helped her in many ways. Because of her husband's work causing him to traavel Mrs. Ruff stays with friends in Montgomery, Prattville and other places in Alabama.

Mrs. Ruff has been trying to get a double lung transplant. Five such transplants have been performed, three in England, two in Canada but none in the U. S.

She presently weighs 90 pounds. In order to obtain the transplant Mrs. Ruff must pay $20,000 now just to continue to be eligible. This amount of money has been raised by various organizations such as churches, Highway Patrol etc. Now the Canadian Hospital and doctors need an additional $180,000. We do not know if there is any possibility of Mrs. Ruff getting this amount.

Mrs. Ruff has two children, one in high school and the other in college. Mr. Ruff works but is in a business which provides just enough money for the family to live.

Senator SHELBY. Doctor, we appreciate your testimony and the examples that you have given us.

Mrs. Amelia Heath. Amelia, welcome to the hearing. I have known Mrs. Heath and worked with her for many, many years. She has been active as the executive director of the FOCUS on Senior Citizens.

Amelia, your written testimony, if any, will be made part of the hearing record without objection. And if you want to add anything to it we will leave the record open, as I have said already several times here today, until April 30.

Go ahead.

STATEMENT OF AMELIA HEATH, EXECUTIVE DIRECTOR, FOCUS ON SENIOR CITIZENS OF TUSCALOOSA COUNTY, AL

Mrs. HEATH. Thank you, Senator Shelby. I appreciate the opportunity to come here today. I did submit something in writing to your office several days ago.

I want to tell you first of all just a few facts about FOCUS, as you have expressed an interest in the community-based services to the elderly. FOCUS is a countywide agency for persons age 60 and above which was established in 1972 by a concerned community group shortly after the 1971 White House Conference on Aging. While not strictly a health service agency, many of our services are health related. Our goal today, as it was 15 years ago, is to help the elderly remain in their own homes as independent as possible and to delay or to prevent institutionalization.

Many of our services are funded in part by Title 3 of the Older Americans Act. Namely congregate and homebound meals, transportation, senior centers and information and referral. In addition, we receive funding from ACTION for the Retired Senior Volunteer Program. We have developed many other programs over the years to meet the varying needs of the elderly in Tuscaloosa. We were the first agency in Alabama to sponsor the Vial of Life, a home alert program to aid emergency personnel to best serve the elderly in their homes in emergencies.

FOCUS also sponsors Telephone Reassurance, the buddy system for congregate housing areas, case management and EDGE, an employment service for people over age 55 who want to work and need to work.

One of our newer programs is CASA, Care Assurance System for the Aged, which, through the use of volunteer groups, assists the elderly at a time when they are most vulnerable; when they are recouperating from an illness or surgery at home after acute care in the hospital.

We are also the provider of homemaker and unskilled respite care under the Alabama Medicaid Program. So, as you can see, we interact with all types of elderly people in many, many different circumstances.

Some of the issues we see include the following: The elderly need help with nursing home expenses. As it stands now, a senior citizen has to become indigent to qualify for help. Is this what we want? No wonder the elderly give up when they go to a nursing home. What does the future hold for them?

The elderly need for all of us to work together to provide a continuum of care, from active prevention-based health and psychosocial programs, to long-term care facilities. Guidelines of program flexibility should be aimed at positive, affirming, and family supportive directions. This continuum of care can actually be less expensive than the restrictive, gap-filled programs of today.

We need the cooperation of the medical community in helping the elderly manage their limited health dollars. Are doctors aware of the fact that the elderly are terrified of going into the hospital and losing control? When specialists (who never seem to take Medicare as full payment) are called in, expensive tests, which may have been done by one physician, are done again with little or no explanation. When that happens, the catastrophe seems to be at hand.

What about the accepted knowledge that with old age comes hearing, eyesight, and dental problems; many of which have a devasting impact on quality of life and cause other resulting problems. These common but serious concerns, the solution to which is beyond the income capability of a significant number of elderly persons, need to be addressed.

Other needs include coverage for the victims of Alzheimer's disease, both in-home and institutional; spousal impoverishment protection; and lastly, a recommendation that physicians who do not elect to accept Medicare as full payment do so if the patients' income is 130 percent or less of the poverty index.

As a point of entry agency for many elderly persons, we are acutely aware of the impact of illness on the elderly and their families. We ask, that in respect to this sturdy, independent and deserving group in our society, realistic and humane solutions be developed. Thank you for this opportunity.

[The prepared statement of Mrs. Heath follows:]

U. S. Senate Special Committee on Aging
"The Catastrophic State of Catastrophic Health Care Coverage"
April 16, 1987
Testimony
of
Amelia Heath
FOCUS on Senior Citizens
of Tusca., Co. Inc.

My name is Amelia Heath and I am the Executive Director of FOCUS on Senior Citizens of Tuscaloosa County. FOCUS, a county-wide service agency for persons aged 60 and above, was established in 1972 by a concerned community group shortly after the 1971 White House Conference on Aging. While not strictly a health service agency many of our services are health related. Our goal today, as it was 15 years ago, is to help the elderly remain in their own homes, as independent as possible, and to delay or prevent institutionalization.

Many of our services are funded, in part, by Title III of the Older Americans Act, namely congregate and homebound meals, transportation, senior centers, and information and referral. In addition we sponsor ACTION's Retired Senior Volunteer Program. We have developed many other programs over the years to meet the varied needs of the elderly in Tuscaloosa. We were the first program in Alabama to sponsor the Vial of Life, a home alert program to aid emergency personnel to best serve the elderly in home emergencies. FOCUS also sponsors Telephone Reassurance, the Buddy System for congregate housing areas, Case Management and EDGE, and employment service for those elderly able and wanting to work. One of our newer programs is CASA, Care Assurance System for the Aged, which, through the use of volunteer groups, assists the elderly at a time when they are most vulnerable; when they are recuperating from an illness or surgery at home after acute care in the hospital. We are also the provider of Homemaker and Unskilled Respite under the Alabama Medicaid Program.

2.

[illegible] elderly [illegible] issues [illegible]

[illegible] nursing home expenses. As it stands now a person might have to become indigent to qualify for help. Is this what we want? No wonder the elderly "give up" when they go into a nursing home. What does the future hold for them?

The elderly need for all of us to work together to provide a continuum of care from active prevention-based health and psychosocial programs to long term care facilities. Guidelines and program flexibility should be aimed in positive, affirming and family-supporting directions. This continuum of care can actually be less expensive than the restrictive institutional programs of today.

We need the cooperation of the medical community in helping the elderly manage their limited health care dollars. Are doctors aware of the fact that the elderly are terrified of going into the hospital and the resulting loss of control? When specialists (who never seem to take Medicare as full payment) are called in, expensive tests (which may have been done by one physician) are done again--with no explanation, the catastrophe seems to be at hand.

What about the accepted knowledge that with old age come hearing, eyesight and dental problems, many of which have a devastating impact on quality of life and cause other resulting problems? These common but serious concerns, the solution to which is beyond the income capability of a significant number of elderly persons, need to be addressed.

Other needs include coverage for victims of Alzheimers Disease, both in-home and institutional; spousal impoverishment protection and lastly a recommendation that physicians who do not elect to accept Medicare as full payment do so if the patients income is 100% or less of the poverty index.

As a point-of-entry agency for many elderly persons we are acutely aware of the impact of illness on the elderly and their families. We ask that in respect for this sturdy, independent and deserving group in our society, realistic and humane solutions be developed.

Thank you for this opportunity to address an issue of greatest national importance.

Senator SHELBY. Thank you, Amelia. Out next panelist is Mrs. Barbara Bonfield. Barbara I want to personally thank you for all the work that you have done to help us bring about this hearing and also for agreeing to testify before this panel today. Your written testimony, I'll go ahead and say this for the record, will be made a part of the record in it's entirety.

You now have an opportunity to say anything you want to regarding the proposals that will be floating around Congress and how you feel about them and what you think we should do.

STATEMENT OF BARBARA BONFIELD, EXECUTIVE DIRECTOR, JEFFERSON COUNTY OFFICE OF SENIOR CITIZENS ACTIVITIES

Mrs. BONFIELD. Thank you, Senator Shelby. And I compliment you on bringing this hearing to Jefferson County, to Alabama, and giving us an opportunity to make comments and to share with you these significant problems that we must deal with.

I can't let pass that, along with George and Senator Heflin, I have roots in Talladega County, having finished Lincoln High School there. And would love to be joining Senator Heflin to visit my mother who still lives over there.

Senator SHELBY. That's a beautiful county and a big one, too.

Mrs. BONFIELD. Thank you. It is an honor to have the opportunity to comment to you today on the issue of catastrophic health care and, specifically, about the administration's proposed legislation to restructure Medicare, particularly part B, to address catastrophic health care needs. You have my written statement and I am just going to highlight today what I have said in that.

Senator SHELBY. You go ahead.

Mrs. BONFIELD. Certainly, the plan has merit. And it's an important first step, as many have said, in helping the elderly pay for a devastating cost that you have heard about from some of our witnesses. It doesn't, however, provide what President Reagan describes as "the last full measure of security for elderly people." The part of the plan that would address the 60th day plus of hospital care is going to affect about 2 percent of the 27 million people that are on Medicaid, that 2 percent that will be in the hospital for day 60th plus. The other 26.5 million people are out there dealing with the catastrophic problems in the community, trying to deal with how to take care of themselves and their older relatives.

Some of the aspects of the President's plan, such as encouraging personal savings for long-term care have merit for those who can afford them. The purchase of IMA's will affect the elderly of the next generation. They probably won't help what we're looking at in this decade, as will the encouragement of purchase of long-term care insurance. And we have heard what long-term insurance care can do to buffer the situation for someone with catastrophic illness.

But this last recommendation, the purchase of long-term care insurance, must take into consideration the experience of the elderly with gap insurance. The confusion, inadequacy, and downright fraud, which has permeated the gap policies, raise a strong issue about what will happen with long-term care policies. And I would suggest that there needs to be very strong regulation, both at Federal and State level, if we go to, and which I expect we will, long-

term care insurance. I would recommend a voluntary part C under Medicare, under the new plan to provide for the long-term. I, frankly, would rather see the Federal Government maintaining an oversight in this area.

But there is one problem with the whole thing that we're talking about, more money—Federal—to the private health care system. Despite the $75 billion that the Government will spend this year on Medicare, the elderly will still spend more out of their own pockets than they did in 1965 when Medicare was established. For that reason, it is essential that we, today, give consideration to the effect that any more patches or band-aids to Medicare will have. For too long the policymakers and the general public have accepted either hospitalization or nursing home care as the only alternatives. And as I look at that chart [4] in front of us, it shows 91.2 percent of the funds going into either hospital or nursing home care. I'm increasingly made aware of this problem.

Dr. Robert Butler discussed this institutional bias of the health care system in his book, "Why Survive, Growing Old in America."

I think that the health care industry, without some ceiling on the top of this pump of new money into the system, will be prepared to soak up those dollars. Be they private insurance, taxpayer dollars, or whatever, as many as you are prepared to send their way. But I want to suggest to you and to your committee that you consider another approach, at least for the majority of older people, who that I mentioned earlier, are going to need some coverage for catastrophic care. With proper assessment and proper services out in the community there are other ways that the majority of older people can be maintained in the community.

Let's admit that we are on the beginning edge of a crisis of a major proportion. And unless we make considerable changes, there is no way that Medicare can meet the needs of those like myself who are middle-aged today. We have a brief period to prepare as those of us who were born in the 1920's and the 1930's pass through the system. Those were the low birth years. But by the year 2010, the boby boom generation will overwhelm the health care system.

Added to the demand of the baby boomers and what they will place on the system, will be the impact of the AIDS epidemic and we have to consider that hand in hand with the demographics regarding aging. That's going to begin to hit us in about 6 years according to what the experts have told me. And without a cure, that situation is expected to escalate right off of the charts. And it's going to impact Social Security and Medicare through disability payments.

It's time to look for more basic models which can provide good quality care, though not necessarily acute and highly skilled medical care. I invite you to look at three relatively simple and comparatively low cost options for addressing the same needs which in the past we have relegated to nursing homes and hospitals. You're going to be involved in re-authorization of the Older Americans Act. And in looking at what the "aging network should be charged

[4] See p. 44.

to do" I ask that the committees of the Senate and the House to charge area agencies on aging with the responsibility and encourage them where necessary, if you have to with funding, and regulatory authority to, (1) develop assisted living facilities throughout their communities; (2) develop concentrated powerful cadres of the young elderly—those that are 55 to 70, just retired—to address the needs of the older elderly; and (3) expand upon Medicare and Medicaid waivered services options to provide more in-home and day-care alternatives.

I base the first recommendation on the experience of our area agency. After hearing from social workers about the concerns of the frail elderly who are in need of protective living arrangements, but who will be driven into poverty by an expensive long-term nursing home stay, we put together an assisted residential living facility; which is affordable and which offers an array of social services.

The total monthly cost to all the parties involved—and there are Federal parties and private parties involved—in making this facility available is $506. Not the $1,500 in the nursing home, not the $2,000 in the nursing home, $506 per person. That includes some Older Americans Act dollars through Title IIIB, and some section 8 dollars through HUD. And then with the older person sharing part of the cost, paying $250 a month out of their own income, they're still left with money of their own. There is an emphasis on prevention and rehabilitation in the setting so that a person can get better and can get back out in the community.

I have provided you with a breakdown on the cost effectiveness of this program in an exhibit (A) to my written testimony.

The second option I have mentioned is that of developing a corps, somewhat like a domestic peace corps of the younger elderly to serve the older more frail group. This is the group that is going to have the time to give to volunteer work in the future. With women, younger women having gone to work, we're going to be dependent on our younger elderly for the volunteer activities that are undertaken. I would propose that this activity provide, maybe, small, part-time stipends if necessary. If not, go straight volunteer, to recently retired people who will in turn provide respite, companionship, and other in-home services to their older counterparts.

The three-fold benefits to this plan are, that you're going to increase the income of those recently retired; provide a purpose to them while drawing on their maturity and experience; and ensure supportive services for frail elderly and the caregivers. And that makes it an especially appealing option.

I know that you have a wealth of information to support the third option of providing home health care to the elderly. Experience in the Hospice Program of keeping the elderly at home throughout a terminal illness has shown that dying at home can be done with dignity—and at a lower cost. You have various demonstration programs which have all been evaluated to show the cost saving benefit of in-home care.

Senator Shelby, these comments represent the major portion of the points that I want to make today. And I will be glad to entertain any questions which you may have.

[The prepared statement of Mrs. Bonfield follows:]

TESTIMONY OF
BARBARA BONFIELD
DIRECTOR, OFFICE OF SENIOR CITIZENS ACTIVITIES
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

Hearings on
Catastrophic Health Care Costs
April 16, 1987

Birmingham, Alabama

Mr. Chairman, and members of the Special Committee on Aging, it is an honor to have this opportunity to comment to you on the issue of catastrophic health care and specifically about the administration's proposed legislation to re-structure Medicare Part B to address catastrophic health care needs.

I must say that the whole area of health care in this country is in a catastrophic state. Like all of our once familiar services, whether it be air travel, telephone or financial services, our services are in upheaval and we are confronted with unfamiliar and myriad choices wherever we go. Do we stay with AT&T for long distance, or use MCI, measured, or regular local service? Do we put our money in an IRA or a money market account, or opt for a deferred comp plan?

For the older person, attempting to fathom all of these choices is bewildering enough. But making decisions about health care, and particularly health care insurance, becomes an impossible task. I have become acutely aware of the problem older people face in looking at Medigap insurance plans.

Our Area Agency on Aging, in attempting to help older people learn more about shopping for gap insurance, has recently conducted several forums to explain the various options, and particularly to look at a proposed competitive medical plan which the Health Care Financing Administration is considering for Alabama.

Now, along with the problem of choosing between AT&T, MCI, Sprint, and all of the other phone service alphabet soup, an older person is asked to make an informed choice between 600 Medigap policies, HMO's, PPO's and now a CMP. I even heard of an HMG the other day.

Consider what happens when into this bewildering hodge-podge of health care choices there appears, to help the unwary older person, a smooth talking, reassuring, insurance salesman. He has with him a variety of appealing policies which do more (according to him) than the one the person already has. And, he has every reason to want to sell a policy since he may get 60 percent of the first year's premium as commission. Is there any wonder that in an elderly high-rise one block from our Area Agency on Aging there are older people with three, four, and sometimes more Medigap policies?

Once he has crossed the hurdle of selecting a gap policy, the older person is confronted by a barrage of beckoning hospitals, seeking him out and enticing him with their services. Competition for the elderly and their Medicare reimbursals is intense in this area and every

hospital administrator and his staff have burnt midnight oil thinking up ways to attract the elderly.

When he gets to the hospital, what may he expect? Frequently, if we are all honest, he will find a large beautifully structured hospital with the latest in equipment, operating at 60 percent occupancy with a portion of the nursing staff laid off. If he needs to be fed his meal, he would be wise to have a family member with him, or a private duty nurse, because staff is stretched and overworked. When the limit of stay for his DRG is reached, he or his family will be told that he must leave the next day.

The hospital social service department will begin diligently helping the family to locate supports. If he is very ill and needs nursing home care, the social worker will have to shop, begging, bargaining and cajoling. Some nursing homes won't take patients who need oxygen, who are tube fed, or need to be turned every two hours.

If the patient cannot afford nursing home care, the case worker may look for an unlicensed boarding home with an owner who is known to give good, if not appropriate, care to this type of patient. Sometimes the social worker may have to find such a facility in another county because the ones in her county are already filled. So the desperately ill patient may be placed in an ambulance and sent to the other county. And, sometimes, gentlemen, a patient dies en route in an ambulance to a county not his own.

This is the situation I see, and our long term care ombudsman tells me about almost daily. There are boarding homes in this county where there are sick patients, with infected decubiti. They are there because they cannot afford nursing home care and they cannot afford, nor or they at an appropriate level, for licensed domiciliary care. Some have been sent here from other counties which have been unable to find resources for them.

Against this backdrop, I will now turn to consider President Reagan's proposed plan to address catastrophic health care needs of the elderly. As I understand it, the plan proposes to (1) restructure Medicare Part B allowing the elderly to purchase for a premium protection from exorbitant costs for hospitals and doctors for treatment of long term acute illness, (2) encourage personal savings for long term care through IMA's and (3) encourage the development of long term care insurance through tax credits.

Certainly, the plan has merit and is an important first step in helping the elderly pay the devastating costs of a major illness. It does not, however, provide as President Reagan has described, "the last full measure of security to

elderly people." The plan provides for amounts over $2,000 in hospital and doctor bills to be picked up by Medicare after a long term hospital treatment for an acute illness. This part of the plan will help about two percent of Medicare's 27 million elderly who will be hospitalized for more than 59 days.

Aspects of the President's plan, such as, encouraging personal savings for long term care, have merit for those who can afford them. Of course, purchase of IMA's will have affect on the elderly of the next generations as will the encouragement of purchase of long term care insurance.

The latter recommendation must take into consideration the experience of the elderly with gap insurance. Confusion, inadequacy, and fraud which have permeated gap policies make one consider the prospect of long term care insurance carefully. Educating the elderly regarding the need, as well as, how to shop for such policies, will be essential. A voluntary Part C under the new plan, to provide for long term care needs, would perhaps be a better option in that it will retain the oversight of the federal government in the long term care area.

There is one obvious problem however with this whole trend toward adding more money, federal or private, to the health care system. Despite the $75 billion the government will spend this year on Medicare, the elderly will spend more out of their own pockets than they did in 1965 when Medicare was established. It is ironic that this program established with the intention of protecting the elderly has allowed a situation where health care costs are inflated and are so devastating for the elderly.

For that reason, it is essential that this committee give serious consideration to the effect that any further band-aids to Medicare may have. For too long, policy makers and the general public have accepted either hospitalization or nursing home care as the only alternatives for frail older people. Dr. Robert Butler discussed this institutional bias of our health care system in his book Why Survive? Growing Old in America.

The health care industry is prepared to soak up more Medicare dollars or private insurance dollars as many as you are prepared to send that way. But, I would like for the committee to consider another approach at least for the majority of older people who can be maintained quite comfortably in their own homes or in assisted living facilities.

First, let's admit that we are on the beginning edge of a crisis of major proportion. Unless we make major changes, there is no way that Medicare can meet the needs of those of

us who are middle aged today. We have a brief period to prepare as those people born in the 1920's and 30's (low birth rate years) pass through the system. But, by 2010 the baby boom generation will overwhelm the health care sector. Today 12 percent of the population is over 65 and consumes one-third of all health care spending. In 2030, 21.1 percent will be over 65. Added to the demand this group will place on the system, will be the impact of the Aids epidemic which will begin to hit us in about six years and which without a cure is expected to escalate right off the charts and impact Social Security and Medicare through disability payments.

It is time for us to look at more basic models which can provide good quality though non-technical care. I invite the committee to look at three relatively simple and comparatively low cost options for addressing the same needs which in the past we have relegated to nursing homes and hospitals. I ask that you charge Area Agencies on Aging and encourage them where necessary with funding and regulatory authority to:

1) develop assisted living facilities throughout their communities.

2) develop concentrated powerful cadres of the young-elderly (55 to 70) to address the needs of old-elderly.

3) Expand upon the Medicare and Medicaid waivered services options to provide more in-home and day care alternatives.

I base the first recommendation on the experience of our Area Agency on Aging. After hearing from social workers about the concerns for those frail elderly who are in need of a protective living arrangement, but who will be driven into poverty by an expensive long term nursing home stay, we put together an assisted living facility which is affordable, and which offers an array of social services.

The total monthly cost to all parties involved in making this facility available is $506.00 per person. This includes the Area Agency on Aging's share from Title III-B (OAA), the Housing Authority with Section 8, (HUD) moneys and the older person who pays on the average $250 from his income. In this setting, the individual receives meals, twenty-four hour supportive staff, assistance with taking baths, medication management, transportation, recreation and counseling from a social worker. There is an emphasis on prevention in this setting. If the older person has been hospitalized, the staff will see that he receives his medication appropriately, and that he receives good nutrition to help the healing process, and exercise to

encourage recovery. Home health care can be delivered in this setting more cost effectively because nurses and aides can see more patients and have reduced mileage to make the visit, etc. Hospital days are reduced and nursing home care is postponed, all at a considerable savings to the various entitlement programs. For details on the cost saving, please see the attached Exhibit A to this testimony.

The second option I mentioned is empowering area agencies, to develop a corps, somewhat like a domestic peace corps, of the younger elderly to serve the older more frail group. This activity will provide part-time salaries to recently retired people who will in turn provide respite, companion and other in-home services to their older counterparts. The three-fold benefits of this plan, increasing incomes, providing a purpose to the recently retired, while drawing on their maturity and expertise, and ensuring supportive services for frail elderly and their care givers make it especially appealing.

A wealth of information is available to support the third option of providing home health care to the elderly. Experience of the hospice programs in keeping elderly at home throughout a terminal illness has shown that dying at home can be done with dignity - and at a lower cost. Various demonstration programs have all been evaluated to show the cost saving benefit of in-home care.

One other area which I ask you to explore is shared cost. When Medicare was enacted it was expected that the federal government through Medicare would pay about 50 percent of the doctor bills while the elderly through premiums would pick up the other 50 percent. Today the Medicare program relies on the federal government through general revenues to pick up 75 percent of the cost.

To address and offset this shift I recommend that the Medicare program set co-payments on Medicare costs based on the beneficiary's ability to pay. It has been my experience that older Americans who can afford it, want and expect to contribute something toward the cost of what they receive. For the elderly of comfortable economic means this is a small price to ask. For policy makers and leaders in the field of aging this policy may seem daring, but I have confidence in the wisdom of older citizens and their desire to share equitably the burden of health care costs and my experience with donations made by older people to Older Americans Act programs makes it possible for me to make this recommendation with confidence. For this recommendation to be credible, however, it must be accompanied by strict regulation of health service provider costs. The elderly will share equitably in the cost only to the extent that they are charged equitably.

SUBSIDIZED RENT CONGREGATE LIVING FACILITY (ABLE)

Needs Identification:

The Office of Senior Citizens' Activities, the designated Area Agency on Aging in Jefferson County, annually conducts a public hearing to determine the needs of the elderly population. A need identified by professionals, as well as consumers, at 1979 hearings was that of congregate housing. While two section eight facilities had been built and more were in the planning stages, housing with services was not available. The need for a congregate housing facility as defined by Housing and Urban Development guidelines, to provide supportive services such as meals, housekeeping, health, personal hygiene, and transportation was identifited. These services are required to assist impaired, but not ill, elderly residents to maintain or return to a semi-independent lifestyle thus avoiding institutionalization as they grow older.

Funding congregate housing was adopted as a major objective by the Office of Senior Citizens' Activities for the FY' 78-79 area plan. At that time OSCA committed $6,000.00 for operational funds and offered technical assistance in the development of the facility. The Young Womens' Christian Association agreed to provide the eighth floor of its ten story building in downtown Birmingham. Following negotiations with OSCA Staff, the Birmingham Housing Authority agreed to provide a rent subsidy under the existing section eight programs. The Jefferson County Commission provided $18,000.00 in Revenue Sharing funds which went toward the renovation of the facility to meet HUD housing standards. An additional $8,000.00 in Older Americans Act fund was provided by OSCA for renovation. Volunteer help from within

the community was provided from several sources. The AFL-CIO Appalachian Council Youths Skill Center provided demolitionists and carpenters; a local technical school provided plumbers; a local architect donated the architectual drawings; and youth groups assisted with painting. The ARLF was ready for occupancy on October 1, 1979.

Program Description:

The facility is located on the eighth floor of the YWCA building which also houses the Office of Senior Citizens' Activities and ElderGarden, the County coordinated Multi-purpose center, ElderGarden, through a cooperative effort of public and/or private agencies, provides social, nutritional, health, recreational, and legal services for the elderly of Jefferson County. The close proximity of the ARLF to ElderGarden enhances residents' access to these services. Presently ElderGarden provides all supportive services while the YWCA manages the facility.

The ARLF consists of nineteen rooms, fifteen of which are being subsidized through the existing section eight program. These fifteen units have private baths, four of the rooms share a bath. There is a large central dining and living room, a laundry room, and a country style kitchen.

Each room is equipped with an emergency call system which can be activated from the resident's bathroom or bedside. The emergency system can be monitored from the resident manager's room and the ElderGarden switchboard. The panel is monitored at all times. The entire facility has carpet and wallcovering and furnishings which provide a cozy homelike atmosphere. To further promote this atmosphere, the residents have been encouraged to bring their own furnishings.

Resident Population:

The resident population is all female with an average age of 76.9 years. At least half the residents were in a nursing home facility before coming to the ARLF. The majority of the older residents were on waiting lists to be admitted to nursing homes. These individuals were not in need of skilled health care, and needed less intensive health and/or supportive social services. Basic services required by most residents were homemaker, transportation, meals, health screening, and counseling. The income of this population is in the low to moderate range.

Average length of stay in the facility has been 13 months with some residents having resided there the full five years of its existence.

Social/Psychological Benefits:

It is recognized that instruments used to measure psychological and/or sociological benefits are often inadequate. However, the social worker, in an attempt to gain this type of information, has developed a monthly assessment chart. In the tenant selection process an assessment tool developed by the Center for Urban Affairs for the Area Agency is utilized, to evaluate the resident's level of functioning. Similar guidelines are used in the regular assessment to determine if changes have occurred. According to these assessments the majority of the residents have shown physical, psychological and social improvement. In addition, through interaction with an observation of the residents, staff persons report a general improvement in the overall adjustment of the residents.

Cost Saving Benefits:

The cost of maintaining an individual for one month in the Assisted Residential Living Facility is $506.47. This includes the resident's contribution and all participating agencies' contributions. In contrast, it would cost an average of $1,100 to $1,400 per month to maintain an individual in a local nursing home. Computed over a one year period for nineteen (19) individuals with the amount paid for institutional care at $1,000 per month, the total cost of nursing home care is $228,000. Savings to the taxpayer, assuming that the nursing home care were financed through Medicaid, is $163,824.84. ($228,000 - $64,175.16).

TOTAL ANNUAL COSTS (BASED ON NINETEEN RESIDENTS)

SALARIES	$ 32,200.00
RENTAL	39 360.00
BOARD	34,200.00
MEALS	9,215.00
MISCELLANEOUS	500.00
	$115,475.00

TOTAL ANNUAL COST TO ALL PARTIES	=	$115,475.00
TOTAL MONTHLY COST TO ALL PARTIES	=	$ 9,622.00
TOTAL MONTHLY COST PER INDIVIDUAL FOR ALL PARTIES	=	$ 506.47

Average out-of-pocket cost to each resident at ARLF is $225.00 ($150.00 for board, $75.00 for rent.) The remainder to be picked up by the housing subsidy and the nutrition project to the elderly is $281.47. Annual cost in federal funds is $64,175.16.

COST ANALYSIS
FOR
ASSISTED RESIDENTIAL LIVING FACILITY

I. Staff Salaries

Manager	$13,000	(100% of time)
Additional staff	$19,200	(night and weekend staff)
TOTAL SALARIES	$32,200	

II. Rental Costs

192 x 15 x 12 = $34,560
100 x 4 x 12 = $ 4,800
TOTAL RENT $39,360

15 residents are paid under the section 8 program at a rate of $192 per month. Four are housed in rooms which do not qualify for section 8 (no private baths) and are only charged $100.

III. Board Charges

A. $150 x 19 x 12 = $34,200

Each resident pays a flat fee of $150 per month toward the household budget. In return she receives three meals per day, seven days per week. The weekday lunches are provided, however, from the Nutrition Program for the Elderly. See below.

B. Value of weekday lunches
19 x 250 = 4,750
meals per year
at $1.94 per meal = 9,215

IV. Miscellaneous Costs $ 500

TOTAL COSTS $115,475

Senator SHELBY. Thank you for your testimony and your candor. As a matter of fact, Barbara, you mentioned the aging to the committee earlier and also reauthorization of the Older Americans Act. We're going to have an Aging Committee hearing in Washington later this month regarding that program. I'll certainly keep your comments in mind when I do this.

Some of you have already touched on your priorities, but just to sum them up briefly for the record, what are the priorities of the members of the various organizations regarding catastrophic health care?

Dr. Layton, do you want to start again and just sum it up?

Dr. LAYTON. Of course, I would like to improve both Medicaid and Medicare, but to have a provision to take care of some problems like we have heard of here today. In other words, catastrophic illness would be a top priority there. And then to also take care of long-term care. Those are our priorities.

Senator SHELBY. Dr. Walter.

Dr. WALTER. Our priorities, of course, are taking care of people who are reaching past 65 and to make certain that they have an opportunity to live a reasonably happy, secure life. We in NARFE are doing a number of things for that, we're concerned about our people, and we're helping them out in every way possible.

For example, I didn't tell you about a telephone call from Mrs. Lofton. Her husband has Alzheimer's disease. This call came within a week after it was announced there is a new drug which promises hope. She asked if I could possibly get her husband in the experimental drug program. I contacted Mr. Pigg who is our first vice-president, living in Birmingham and who earlier contacted the University of Alabama in Birmingham, the medical school about Alzheimer's disease research. There is some research being done there. I gave the telephone number and the name to Mrs. Lofton. And I said, however, you will have to pursue this further through your own doctor, which she did. Her husband now is on the research program at the University of Alabama here in Birmingham.

This month, April, is NARFE Alzheimer's disease month. We are raising funds for it. I think it will be of interest to you to know that a city, Fort Payne, north from here, has 66 members in NARFE and they have raised over $2,000 to provide research in this particular area. We hope to have a considerable amount of money raised among our own members for this research.

We made efforts to get this money, at least, as much of it as possible, kept in the State of Alabama for research. We do want to help the national Alzheimer's disease research too. But our program is to provide, not for just simply members of NARFE, a reasonable living after 65, but for all people.

Senator SHELBY. Thank you. Amelia Heath, just briefly, what is your priority regarding this?

Mrs. HEATH. Well, I think that that's pretty easy for me to say because one of the things that I hope this insurance will do is something that Barbara alluded to and that is, to provide a real continuum of care. One of the things that I think is kind of ironic or humorous is the title of the insurance that we all talk about called medigap, the operative word there is gap, it is a gap. I mean,

it's not a gap filler. And that leads to a lot of misunderstanding. People——

Senator SHELBY. It's very misleading to a lot of people?

Mrs. HEATH. It is. They think they filled the gap, so it's a very unfair name. So many people approach this problem as they get older and they have as you said earlier, think that they are covered or that something—somehow they're going to be covered and they don't plan. Part of the problem then is the hysteria and the misunderstandings that arise as additional family problems. So we really want the solution to be not just another isolated little segment that deals with a small, fairly, untypical situation.

We would really like for the people at the congressional level to understand what the word "catastrophe" means to old people. As Barbara was mentioning, very few people stay in the hospital past 60 days. There are a lot of things, about the new legislation, that doesn't really relate to older people as a large group. We would like to see more realistic goals set. We would like to have more recognition that long-term care is not synonymous with final care.

Senator SHELBY. That's a good statement.

Mrs. HEATH. Yes. We see a cycle, your pie chart is a circle, circles are very popular. We see people in their homes, we see them in the hospital, we see them in long-term care institutions, nursing homes, et cetera and then we see them back home. Older people want to be at home, they need to be at home. I don't want to see a system that's designed—as the system we have is designed, that a nursing home is a dead end.

Senator SHELBY. Barbara, you did a good job on summing up a minute ago. Briefly, tell us your top priority, if you have one.

Mrs. BONFIELD. The one thing I want to see is that we build systems for long-term care so that we can meet this crisis that I described earlier. And that we have the means and the leadership to begin to put in place models that can provide quality of life at a lower cost to all of us for our older people and those who are not quite elderly.

Senator SHELBY. One last question for this panel. What can you recommend to this committee that we do, possibly, on the Federal level, and the State and the local community levels, while we wait for Congress to act on the various proposals? Our elderly—we need to make sure that our elderly are receiving as much as possible in the way of community services.

Mrs. BONFIELD. Well, I think we have to put in place just as much as we possibly can. As an Area Agency director, we have been trying to do that for the last 10 years, bringing together all kinds of funding to put together the kinds of programs that Amelia and I have been talking about, the assisted living, and volunteer programs. That's the kind of programs that can mean so much to an older person. I think until we get some other things in place, this is what we must work on.

Senator SHELBY. Dr. Layton.

Dr. LAYTON. I think we have some resources available locally that may be eligible for Medicaid. If you look into it, here in Jefferson County and other places, it might save some money on a 3 to 1 basis that we're not going to put those people who—about 50 percent of them are eligible for Medicaid who are not on Medicaid. I

think the money is already here, it's just a matter of to get them allowed to use it in time.

Senator SHELBY. Dr. Walter, do you have a comment?

Dr. WALTER. Yes. The comment that I have, Senator Shelby, deals with Government agencies. The Allen McGee case, he is a disabled World War II veteran, yet the Government's hospital will not take him. I do not know the details, I have some of the details, but I don't know why they will not take him.

Senator SHELBY. I don't know why either. And it might be that he does not come under what they call the criteria. But if he is a World War II veteran they ought to take him. And I would like to work with you. My staff is here. If you meet Mr. Dearman who is here, and some other people on my staff after you leave this panel, we will try to help you.

Dr. WALTER. I think that there is money available. I would like to also say that from my point of view at least, I may not be expressing NARFE's complete philosophy on this, but we have private institutions, churches, and other social organizations that can help, if not necessarily in money, money is not the only thing that we need in these cases. We need sympathy, we need encouragement, we need visitation and I can go on down a whole list of things here. But most of this is outside the realm of Government. It's in the realm of just being a good citizen and a good person and caring for your neighbor. And this is something that I think we can do.

Senator SHELBY. Thank you all. I want to again express my thanks to you on behalf of the Special Committee on Aging of the U.S. Senate for appearing here with us today.

We have another panel, this will be our last panel, they're a very important one. Dr. Allan Goldstein, Mrs. Beverly Friedlander, Ms. Karen Hermanson, and Mr. Joseph Bolen. And while they're coming up to the witness panel table, I want to share some of the backgrounds on these people.

Dr. Allan Goldstein. Dr. Goldstein has been a practicing physician for 15 years here. He specializes in pulmonary disease and internal medicine. A great many of the patients of Dr. Goldstein's are older adults. And as a result, Dr. Goldstein is quite familiar with the health coverage problems that many of the elderly face.

Dr. Goldstein, I want to thank you for giving your time to us today, to be with us and for sharing with you—with us the physician's perspective into this issue of catastrophic health care.

Mrs. Beverly Friedlander. Mrs. Friedlander is here. Mrs. Friedlander has for the past 5 years been the social work manager for St. Vincent's Hospital, a major hospital for many, many years here in Birmingham. Mrs. Friedlander is a discharge planner responsible for assuring continuity of care for acute care patients. In practice that means that she does her best to assure that when patients leave the hospital, they receive the type of follow-up care, whether that be through a home care agency, a rehabilitation hospital or a nursing home, that they require. I look forward to Mrs. Friedlander's testimony along with the others.

Another panelist that we have here is Ms. Karen Hermanson. Ms. Hermanson has been the director of the Birmingham Visiting Nurse Association since 1983. In addition to her work with VNA,

Ms. Hermanson was formerly a vice president of a hospital for 7 years, she has been very involved in health care. She is now responsible, with the limited resources available to her, for providing nursing and home care services to the frail and elderly in their homes. These services are known as home health care services. And it is my hope that we will be hearing a lot more of these and their expansion in the months to come.

Mr. Joseph Bolen. Mr. Bolen, I would like to welcome you to the hearing. He is the vice president of Provider Affairs for Blue Cross-Blue Shield of Alabama. If there is any one insurer here who knows a great deal about the Medicare Program, it's certainly Blue Cross-Blue Shield. At this moment, Blue Cross-Blue Shield underwrites 45 percent of all Medicare, supplemental or medigap policies in the entire Nation.

Before we begin, Mr. Bolen, because I understand you have been recently promoted, I would like to take this opportunity to congratulate you on your new job.

Mr. BOLEN. Thank you.

Senator SHELBY. Although this is a new job to you, I'm aware that you're not a new person in the field, as you have been involved in the health care delivery and the insurance industry for the past 18 years. I'm sure you have much to offer us in this field hearing. I welcome all of you as I have said.

Dr. Goldstein, do you want to lead off. Your written testimony will be made part of the record in its entirety for the Special Committee on Aging for the U.S. Senate. You may proceed.

STATEMENT OF DR. ALLAN R. GOLDSTEIN, PRACTICING PHYSICIAN, BIRMINGHAM, AL

Dr. GOLDSTEIN. Mr. Senator, I appreciate having the opportunity to be here. I have submitted my written statement.

Senator SHELBY. It will be made part of the record.

Dr. GOLDSTEIN. I will just summarize and add a few points. My name is Allan R. Goldstein, I am a physician practicing in Birmingham, Alabama. My comments today are based on, one, my professional experience as a practicing specialist in internal medicine and pulmonary diseases who sees the patient regularly who is suffering from catastrophic illness; and two, my own personal experience of having both my parents die of cancer.

I define catastrophic illness as an acute or chronic illness requiring hospitalization and/or nursing home care and/or the regular use of medication that leads to an inability to be gainfully employed and/or perform the activities of daily life.

There are many examples of people who have had to pay money out of their pockets because whatever insurance they had did or did not cover the services they needed. You have heard numerous examples of that today, and I will not belabor the issue because the examples that you have already heard, I can't impress upon the Senator and the people in this room any more than that which has been said. There is a problem with those people having to pay for it.

The real problem, as far as I'm concerned, is the method in which we are going to try to reimburse the care of people with cat-

astrophic illness. It's very disturbing to me that before this program has even been passed by the Senate and the House of Representatives, we already have a planned premium increase for years 2 and 3. That's extremely bothersome as a practicing physician who spends considerable time talking to my patients about their financial situation. The DRG system has not adequately reimbursed for catastrophic illness. And unless that system is altered, it will continue to discriminate against the seriously ill patients.

The CMP has been looked at as a possible answer. However, the recent experience with the Marshfield Clinic is very sobering. Despite an efficient system which decreased hospitalization by 252 per 1,000 days, a loss of $3 million was realized because of an inadequate reimbursement system.

The private insurance industry has not done all that it can do either. Most medigap programs cover only the services, allowed by Medicare. And what most Medicare recipients don't understand, and what most of the public does not understand, is the Medicare allowance does not necessarily have any direct relationship to what a fee is as far as being reasonable. A reasonable fee will vary with every single insurance company. So that we have a problem understanding what allowable means. The uncovered service and the portion above the allowable is paid for by the patient unless the physician and the patient, which is not an uncommon problem, sit and talk about the patients' financial situation. I know in our practice, if the patient has a financial problem, we waive whatever they can't pay. But we do that as a personal discussion between doctor and patient so that we remain their advocate, not their adversary, which I think is extremely important in whatever program that we develop.

The concept of retrospective denial is terrible. It's something that the Government needs to look at very carefully. For those who do not understand what this means, it is very simple. I provide a service that the patient and I have decided is necessary based on the evaluation that is done in my office based on information that the patient has given to me. Sometime in the future after the service has been delivered, the insurer decides that this is uncovered and, therefore, either refuses to pay or recoups money. That is only to the benefit of the third party insurer, it is not to the benefit of the system. The argument has been used that this will stop unnecessary care. I don't totally believe that being involved in utilization review, it would stop unnecessary care. I think we have systems available already called utilization review pre-admission certification which do work. And unfortunately, Medicare stopped preadmission certification because "it was costing too much," but now they can deny retrospectively after the patient has been treated. And I have just received one of those little notices on a patient that I get nothing for her care. The patient later died with her illness, and one of her admissions was denied by a reviewing board who absolutely could not have looked at that record nor any previous record, but it is to the advantage of the system not to pay after the patient has been treated.

It has been suggested that catastrophic illness be covered under the capitation program of HMO's, PPO's or other private insurers. Under capitation, I feel that we are going to have regular denial of

services. Most of the data that is available on capitation is based on young healthy people. We are not dealing with young healthy people. We're dealing with people who have chronic illness; who have reason to go to the doctor; who have reason to take medication.

We have already seen that the major cost is nursing home care; it is not the cost of their medication; it is not the cost of their physician visit. If we go ahead and base a system of capitation on young healthy people we will inadequately reimburse and we will, therefore, have people uncared for again. And the whole purpose of this is to get people cared for, not to see how much someone can make. And by fair reimbursement, I do not wish to be misread. I am not saying whatever anybody wants to put down as a fee, I truly mean, fair, based on what services are necessary.

There is no doubt that some form of catastrophic health care is necessary. It would be irresponsible for any physician or any health care organization to oppose in principle this type of coverage. However, we must be extremely careful how we finance the programs, so as to avoid denial of care, supposedly in the name of cost containment, but in reality, to the financial benefits of any provider or insurers. But in trying to determine what service should be covered and what reimbursement is fair, might I suggest to the committee that you carefully compare the plan that you are asking our senior citizens to accept with that plan which is now available for Federal employees or retired military personnel. And having had direct experience with that, I wish I could have insurance coverage that would be as adequate and I would feel very secure. I do not wish to say that those people are getting too much. I do that as a point of reference.

Since submitting my written remarks to you we have had more examples of people who cannot get into nursing homes because they don't have money. We have one man right now in the hospital who is 93-years old who has been in and out of the hospital at an extremely high cost. Because he is indigent, the hospital foots the bill on an indigent care plan which they have and which they are obligated to provide. This man has for 3 months now been on a waiting list at a nursing home, and we accidently got ahold of the administrator of that nursing home and he was embarrassed to realize that we knew that this man was being passed over regularly because no money was available. And we see that over and over.

I practice medicine because I consider myself a professional. I have tried to give my patients adequate care. I do not want to see any system that causes me to be an adversary or denies patients the care to which they are entitled. Within a few years I probably am going to be on the other side of the coin. And I want to make sure that while I had the opportunity that I took some part in helping to shape something that was reasonable and gave us all a chance to go on in our later years in a respectable manner.

I appreciate very much having had this opportunity. And I am available to the Senator at any time.

Senator SHELBY. Thank you, Doctor.

[The prepared statement of Dr. Goldstein follows:]

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April 6, 1987

Testimony on Catastrophic HealthCare Coverage
before the Special Committee On Aging of the
United States Senate

Mr. Senator and Members of the Committee:

My name is Allan R. Goldstein. I am a physician practicing in Birmingham, AL. My comments today are based on: (1) My professional experience as a practicing specialist in internal medicine and pulmonary diseases who sees patients regularly who suffer from catastrophic illness, and (2) My own personal experience of having both of my parents die of cancer.

Catastrophic illness can be defined as any acute and/or chronic illness requiring hospitalization and/or nursing home care and/or the regular use of medication that leads to an inability to be gainfully employed and/or perform the activities of daily living.

For those with catastrophic health problems the availability of services is not the problem. Rather, the financing of those services limits the care that is received by the patient. Let me give some examples: (1) A 75 year old man with recurrent lung infection responsive only to injectable antibiotics. His family was taught how to give the medication and the patient had an intravenous line surgically placed into a large vein in his chest. Medicare would not pay $75.00 per day for home medication but would pay for three visits to a hospital emergency room for the same medication at a cost of $105.00 per day. Besides the increased cost to the system, the patient had to travel twelve miles one way to reach the emergency room. The only alternative

was hospitalization at a cost of $3500.00 for a ten day course of antibiotics or the patient would have to pay $750.00 out of his own pocket for that same treatment.

(2) A 70 year old man with replacement of a cardiac valve because of endocarditis. A post-operative course of antibiotics of six weeks was indicated. Home care was possible but payment for antibiotics was denied. The choices - continued stay in the hospital or a six to seven thousand dollar cost to the family.

(3) Many patients are denied coverage for continued care in nursing homes for less expensive, but necessary services. These patients then leave the acute hospital for their home where they receive inadequate care and are back in the hospital in a matter of weeks.

(4) Failure of the Medicare system to reimburse for influenza vaccine, despite data documenting the increased morbidity, mortality and hospitalization in senior citizens who do not receive the vaccine. The result, preventable catastrophic illness.

The real problem is what method will be used to finance the proposed catastrophic health plan. It is very disturbing to me that before the program is even in place, annual premium increases are already planned for years two and three. The DRG system has not adequately reimbursed for catastrophic illness and, unless it is altered, will continue to discriminate against the seriously ill patient. The CMP has been looked at as a possible answer. However, the experience of the Marshfield Clinic is very sobering. Despite an efficient system which decreased hospitalization by 252 per 1000 days, a loss of $3,000,000 was realized because of inadequate reimbursement to the system. The private insurance industry has not done all it can. Most Medigap programs cover only the services and fees allowed by Medicare. This leaves a significant gap in the amount charged vs. the amount paid. This leads to increased costs to the senior citizen. The concept of retrospective denial is also troublesome and may lead to increased costs to our Medicare recipients. In retrospective denial, services already provided are judged to be unnecessary and therefore not subject to

[illegible] one of several organizations, including third party payers, who [illegible] had no direct contact with the patient. Not only will we see an overall increase in cost of healthcare because of retrospective denial, but the quality will decrease.

If catastrophic coverage is paid for by capitation of HMO's, PPO's or private insurers, I fear we will see regular denial of services because of the profit motivation. Capitation for senior citizens and as a way to prevent and reimburse for catastrophic illnesses is illogical and cannot be based on any data obtained from insuring young, healthy people under a capitation program. To make matters even worse, we have already seen examples of third party carriers changing billing codes so as to pay less for the services rendered to a patient. This, ultimately, leads to an increased cost to the patient.

There is no doubt that some form of catastrophic healthcare coverage is necessary. It would be irresponsible for any physician or healthcare organization to oppose, in principle, this type of coverage. However, we must be extremely careful in how we finance this program so as to avoid denial of care supposedly in the name of cost containment but, in reality, for the financial benefits of any provider or insurer. When trying to determine what services should be covered and what reimbursement is fair, might I suggest to the Committee that you carefully compare the plan that you are asking our senior citizens to accept with the plan that is now available for Federal employees and retired military personnel.

Thank you very much for allowing me to testify before you. I hope that the final plan will place the medical needs of the citizens of this country ahead of politics or the vested interest of the few.

Senator SHELBY. Mrs. Friedlander, your testimony of course—your written testimony will be made part of the record without objection. And if you want sum up your statement now for me, you may.

STATEMENT OF BEVERLY L. FRIEDLANDER, SOCIAL WORK SERVICES MANAGER, ST. VINCENT'S HOSPITAL, BIRMINGHAM, AL

Mrs. FRIEDLANDER. Thank you Senator Shelby. I would like to say that I appreciate very much having the opportunity to express my profession's perspective regarding the problems addressed here today. I represent St. Vincent's Hospital where I am employed as the manager of the Social Work Services Department. As you know, St. Vincent's Hospital is a part of the Daughters of Charity Health Care System. Their mission for the next few years, beginning now, is to give top priority to the needs of the poor and elderly.

My department at St. Vincent's is responsible for assuring continuity of health care for our hospital's patients. Because of that role, I feel that I'm very much an advocate for the elderly in addition to representing my institution here today.

I would like to address the long-term health care needs of the elderly as the issue of importance today. Acute catastrophic illness strikes only 2 percent of the elderly population. For the other 98 percent, it is the cost of long-term care that drains their individual finances and strains the overall health care system.

Chronic disability among our Nation's elderly resulting from arthritis, cardio-vascular problems, lung disease, hearing and vision impairments and mental disturbances causes this population to become increasingly dependent upon other people for assistance in their daily lives. The disabled elderly require long-term sustained and continuous care that includes monitoring of medications, meal preparation, housekeeping and chore services, shopping and errands, intermittent or continuous personal care, rehabilitation and skilled nursing care. Approximately 30 percent of people over 65 years of age require some assistance to function in their daily lives. About 18 percent of the elderly require major help from another person. An additional 5 percent of the elderly need to be institutionalized. Because of a rapid increase in the population over 65 years of age, and particularly in those over age 85, our health care delivery system must begin to address chronic disability as an expectable condition for which provision must be made. It is projected that one out of four adults over age 80 will require long-term care and that long-term care costs for those 80 and over will increase fivefold by the year 2030.

One of our primary goals in medical social work is to help our elderly disabled patients postpone or avoid unnecessary nursing home placement. The desire of most older people to remain in their homes and communities, coupled with the high cost of institutionalized care, has created an increased demand for home and community based supportive services. Unfortunately, under the present system, Medicare covers only a few of these services—intermittent personal care, rehabilitation, and skilled nursing visits. The Medic-

aid waiver program has made it possible for some people to obtain other home based services including homemaker services, respite care and case management; but there are only a limited number of slots available under the Medicaid waiver program and the delays in service implementation impede the continuity of care that is so critical for patients leaving the hospital. In addition, only patients covered under Supplemental Security Income are eligible for the Medicaid waiver program, that is patients who have low income. Only 4 percent of the elderly who need assistance with activities of daily living, that any part of it is paid for by the Government.

Who then is providing for the long-term care needs of our aging population? As the "informal" system of care, families provide the vast majority of medically related supportive health and social services. We have heard testimony today from two of those families. Families take the disabled elderly into their homes when they are no longer capable of independent living. These families respond in emergencies, provide intermittent care, implement rehab procedures and give emotional support; but at what cost? They also suffer economic strain and as many as 50 percent experience significant mental health symptoms.

I would like to cite some representative cases from my hospital experience to illustrate these points.

Mrs. M. is the granddaughter of a 93-year-old patient with severe vascular disease. She is the only surviving family member left to care for this aging patient. Mrs. M. has spent $40,000 over the last 4 years in trying to provide for the long-term health care needs of her grandmother. She candidly admits that she feels much resentment mixed in with her obvious concern and affection.

The second case is that of Mrs. C. who is the daughter of an 83-year-old Alzheimer's patient. Mrs. C. is now in desperate need of inpatient psychiatric treatment herself as a result of the emotional strain of trying to hold down a job in order to provide for her mother's daytime care and then providing total care for her after working hours. She wonders how she can afford or find the full-time caregiver that she will have to provide for her mother when and if she decides to be admitted to an inpatient psychiatric treatment program. There are also opportunity costs incurred when spouses and adult children have to leave the work force and focus on the caregiving responsibility. In spite of the emotional and economic strain, families will continue to provide for their aging relatives in their homes until they can be convinced that their own health is at risk or that the patient could be provided with more appropriate care in an institution.

Unfortunately, when the patient enters the nursing home the family's responsibility does not stop. In 1985, Medicare covered less than 2 percent of the $35 billion spent on nursing home care last year. Private insurance paid even less. Families paid more than half, $18 billion, with Medicaid picking up the rest for those whose resources were exhausted. Nursing home patients are expected to "spend down" to Medicaid poverty levels. Now, let me state, that in Alabama this means assets totaling no more than $1,800 and that includes your home and car. They're also expected to deplete the inheritance they had intended to leave for their children. The spouse that remains at home is left with diminished resources from

which to draw if he or she should become disabled and need long-term health care services also.

As an advocate for the elderly and from my work in a hospital setting, I would like to speak for those elderly disabled individuals who do not have family. There is a real tragedy here as the situation becomes even more complex and difficult in trying to obtain long-term care. For the majority of our elderly patients whose hospital stay extends well beyond the acceptable length of stay, there is one simple reason—there is no place for them to go. With no family to sponsor them, patients cannot be admitted to most nursing homes with the exception of the County Home which has a waiting list 6 months long. Given the limitations of home care services covered by Medicare, returning home is not a feasible continuing care option unless the patient can afford to hire full-time care. Domiciliary care is an option only if the patient is not considered "bedbound", but the average cost of this type of care is $900 a month. For most of our patients living on Social Security, this type of care is simply not affordable. In most cases, the medical social worker must seek court-ordered guardianship in order to appropriately assess the patients' needs and get them into a nursing home where they hopefully will be eligible for Medicaid coverage. The guardianship process takes a minimum of 1 month. For these patients, the frustration of knowing that they will never return home is compounded by the anxiety associated with nursing home placement.

Our elderly patients and their families are continuously surprised and dismayed to learn that Medicare and private insurance coverage for long-term care is very limited. A 1984 study by the American Association of Retired Persons found that 79 percent of the potential aged consumers reported that they thought Medicare covered them for long-term care, although it does not. Media marketing methods perpetuate the myth by featuring well-known television personalities who convince consumers that certain private insurance policies will cover them for long-term care. Almost 70 percent of the elderly are covered by some form of medigap policy, almost none of which cover continuity of care beyond the acute stage. This lack of awareness by aging families is the barrier to the perception of long-term care as an economic catastrophe that should be anticipated and insured against.

Many lawmakers realize that the current medigap policy proposal will affect only a small portion of the larger problem—long-term care. Recently, several pieces of legislation that support improved home health care coverage and incremental changes in nursing homes have been introduced. What is still needed is legislation that will truly provide the elderly and their families with the "last full measure of security" against the risk of catastrophic long-term care. Several solutions should be included in any comprehensive plan that addresses the problem of catastrophic illness.

Loosen the intermittent and homebound criteria for Medicare home health care and institute a case management function to ensure that benefits are provided in the most cost-effective manner.

Explore the possibility of converting the Medicaid 2176 waiver program into a State option under Medicaid with a requirement for case management services.

Explore options to prevent spousal/dependent impoverishment under Medicaid such as a Federal/State loan program.

Authorize research and demonstrations for studying incentives for increasing the availability of long-term care insurance and the use of managed care approaches for improving long-term care benefits under Medicare and Medicaid.

In closing, I would like to stress that protection for long-term care needs will help families to do what they have been doing and want to do to help the elderly, and would prevent family breakdown that results from the emotional and physical strain so many experience. The issue, in terms of public policy, is to protect the aging family as well as the disabled elderly individual from catastrophic need.

Senator SHELBY. Mrs. Friedlander, thank you very much for your concern.

[The prepared statement of Mrs. Friedlander follows:]

Testimony on

LONG TERM CARE OF THE ELDERLY

BY

BEVERLY L. FRIEDLANDER, MSW

Before the field hearing
of the United States Senate
Special Committee on Aging

My name is Beverly L. Friedlander. I am the Manager of Social Work Services at St. Vincent's Hospital in Birmingham,Alabama. My department is responsible for assuring continuity of quality health care for our hospital's patients - be it oupatient hospital care, home health care, adult day care, assistance with basic physical and home management activities or nursing home care. I would like to address the real catastrophic issue of long term health care for our aging population.

You have heard testimony regarding the significant gaps in health care coverage provided by Medicare and other insurance plans that are now being given greater attention as the nation's population ages and becomes more dependent on the health care delivery system. Given these facts we should then turn to the basic truth of the problems that need most to be addressed. First, acute catastrophic illness strikes only a small percentage of the elderly, Medicare population. For the other 98 percent, it is the cost of long-term care that drains their individual finances and strains the health care system.

Chronic disability among our nations's elderly - resulting from arthritis, heart and vascular problems, lung disease, hearing and vision impairments and mental disturbances - causes this population to become increasingly dependent upon others for assistance in their daily lives for prolonged periods of time. The disabled elderly require long-term, sustained and continuous care that includes monitoring of medications, meal preparation, housekeeping and chore services, snopping and errands, intermittent or continuous personal care, rehabilitation and skilled nursing care. Approximately 30 percent of people over 65 years of age require some assistance to function in their daily lives. About 18 percent of the elderly require major help from another person. An additional 5 percent of the aged are institutionalized. Because of the increase in the population over 65 years of age, and particularly in those over age 85, our health delivery system must begin to address chronic disability as an expectable condition for which provision must be made. It is projected that one out of four adults over age 80 will require long-term care and that long-term care costs for those 80-and-over will increase five-fold by the year 2030.

One of our primary goals in medical social work is to help our elderly disabled patients postpone or avoid unnecessary nursing home placement. The desire of most older people to remain in their homes and communities - coupled with the high cost of institutionalized care - has created an

increased demand for home and community based supportive services. Unfortunately, under the present system, Medicare covers only a few of these services - intermittent personal care, rehabilitation and skilled nursing visits. The Medicaid waiver program can supplement these services with homemaker services, case management and respite care, but there are only a limited number of slots available under the waiver program and the delays in service implementation impede the continuity of care that is so critical for patients leaving the hospital. In addition, only patients covered under Supplemental Security Income are eligible for the Medicaid waiver program, i.e,patients who have low incomes. Only 4 percent of the elderly who need ADL assistance have any part of it paid for by the Government.

Who then is providing for the long-term care needs of our aging population? As the "informal" system of care, families provide the vast majority of medically related supportive health and social services. Families take the disabled elderly into their homes when they are no longer capable of independent living. These families respond in emergencies, provide intermittent care, implement rehab procedures, and give emotional support; however, they also suffer economic strain and as many as 50 percent experience significant mental health symptoms.

*Mrs. M., the granddaughter of a 93 year old patient with severe vasular disease, is the only surviving family member left to care for this aging patient. Mrs. M states that she has spent $40,000 over the last four years in trying to provide for the long term health care needs of her grandmother. She candidly admits that she feels much resentment mixed in with her obvious concern and affection.

*Mrs. C. is the daughter of an 83 year old Alzheimer's patient. Mrs. C. is now in desperate need of inpatient psychiatric treatment herself as a result of the emotional strain of trying to hold down a job in order to provide for her mother's daytime care and then providing total care for her after working hours. She wonders how she can afford or find the full-time caregiver that she will have to provide for her mother when and if she decides to be admitted to an inpatient psychiatric treatment program.

There are also opportunity costs incurred when spouses and adult children are forced to leave their jobs to focus on the caregiving responsibility. In spite of the economic and emotional strain, families will continue to try to provide for their aging relatives in their homes until they can be convinced that their own health is at risk and that the patient could be provided with more appropriate care in an institution.

Unfortunately, the family's responsibility does not stop when the patient enters the nursing home. In 1985, Medicare covered less than 2 percent of the $35 billion spent on nursing homes that year. Private insurance paid even less. Families paid more than half, $18 billion, with Medicaid picking up most of the remainder for those whose resources were exhausted. Nursing home patients are expected to spend down to Medicaid (poverty) levels (in Alabama, this means assets totalling no more than $1700 including your home and car) and expected to deplete the inheritance they had intended to leave for their children. The spouse that remains at home is left with diminished resources from which to draw if he/she

should become disabled and need long-term health care services also.

*Mrs. B. is the wife of a 75 year old chronic lung disease patient who has recently been diagnosed with terminal cancer. Mrs. B. realizes that she will no longer be able to care for her husband at home but worries about spending half of their combined savings on his nursing home care until he is "Medicaid eligible" because she still has an adult retarded son at home to care for.

For those elderly, disabled patients who do not have families, the problem of obtaining long term care services becomes even more complex. For the majority of our elderly patients whose hospital stay extends well beyond the acceptable LOS based on intensity of service and severity of illness criteria, the reason is simple -- there is no place for them to go. With no family to sponsor them, patients cannot be admitted to most nursing homes with the exception of the County Home which has a waiting list six months long. Given the limitations of home care services covered by Medicare, returning to the home is not a feasible continuing care option unless the patient can afford to hire someone around the clock to assist with activities of daily living (ADL, i.e., bathing, feeding, dressing, mobility, transferring and toileting). Domiciliary care is an option only if the patient is not considered "bedbound," but the rates for this type of care average around $900 a month. For most of our patients living on fixed Social Security incomes this type of care is simply not affordable. In most of these cases, the medical social worker must seek court-ordered guardianship in order to appropriately assess the patients' assets and get them into a nursing home where they hopefully will be eligible for Medicaid coverage. The guardianship process takes a minimum of one month to finalize. For the patients who retain some of their cognitive abilities, the frustration of knowing that they cannot return home is compounded by their anxiety associated with the dread of the nursing home placement and the anticipated boredom and loss of dignity and control that they fear will come with it.

Our elderly patients and their families are continually surprised and dismayed to learn that the Medicare and private insurance coverage for long-term care is very limited. A 1984 study by the American Association for Retired Persons found that 79 percent of the potential aged consumers reported that they thought Medicare covered them for long-term care, although it does not. Media marketing methods perpetuate the myth by featuring well-known television personalities who convince consumers that certain private insurance policies will cover them for long-term care. Almost 70 percent of the elderly are covered by some form of Medigap policy, almost none of which cover continuity of care beyond the acute stage. This lack of awareness by aging families is the barrier to the perception of long-term care as an economic catastrophe that should be anticipated and insured against.

There is general consensus that society's response to the needs of the individual and the family for continuity of care has been inappropriate and inadequate. Many lawmakers realize that the current additional medigap policy proposal providing protection against catastrophic extended hospital stays will affect only a small portion of the larger problem -- long term care. Subsequently, several pieces of legislation that support improved home health care coverage and incremental changes in nursing home and other long-term care services have been introduced and are receiving some

attention. What is still needed is legislation that will truly provide the elderly and their families with the "last full measure of security" against the risk of catastrophic long-term care. Protection for long-term care needs will help families to do what they have been doing and want to do to help the elderly, and would prevent family breakdown that results from the emotional and physical strain so many experience. The issue, in terms of public policy, is to protect the aging family as well as the elderly disabled individual from catastrophic need. The following solutions should be included in any comprehensive plan that addresses the problem of catastrophic illness:

* Loosen the intermittent and homebound criteria for Medicare home health care and institute a case management function to ensure that benefits are provided in the most cost-effective manner;

* Explore the possibility of converting the Medicaid 2176 waiver program into a state option under Medicaid with a requirement for case management services;

* Explore options to prevent spousal/dependent impoverishment under Medicaid such as a federal/state loan program through which a family could "borrow" against the beneficiary's estate to meet the cost of long term care;

* Authorize research and demonstrations for studying incentives for increasing the availability of long term care insurance and the use of managed care approaches for improving long term care benefits under Medicare and Medicaid.

Senator SHELBY. And next we will hear from Ms. Hermanson. And may I say, that the record will remain open until April 30 if you have anything else you would like to add.

STATEMENT OF KAREN HERMANSON, DIRECTOR, VISITING NURSE ASSOCIATION, BIRMINGHAM, AL

Ms. HERMANSON. First of all, I want to express my gratitude to you, Senator, for having us here for this hearing. I have been very impressed with the testimony we have heard so far. I read the testimony that was held at the joint committee hearings earlier this year and I tried to read as much as I can about it.

One of the things I am struck with is the complexity of the issue as demonstrated in the diversity of opinions. But the one thing I want to mention is that there are a lot of similarities. So I restrict my comments to, maybe, some of the newer points, the main points.

Senator SHELBY. Like Dr. Goldstein pointed out. You have got to cover a lot of ground because there are a lot of situations.

Ms. HERMANSON. Yes, there are. But there is a lot of complexity and diversity, but there is also a lot of similarity. So I'll try to restrict my comments to the main points, as perhaps, I have already submitted in my testimony.

The main thing that I read about and hear about is how much will this thing cost? But my main point is how do we know how much it is going to cost until we develop a system which is most cost effective? If you are looking for how to fund the program, first find the most cost-effective program and then fund that program. What is cost effective? I think, cost effective is restoring that victim of catastrophic illness back to a maximum level of a functioning in the shortest time and at a reasonable cost. Whether it's independence, or not, you need to restore the patient/family back to their maximum level of independence. I think someone mentioned about the revolving door, let's just not just look at catastrophic illness as ending with a person being in a nursing home or acute care setting, let's look at restoring them and bring them back into the mainstream of life.

How do we do that? I think that we should focus on producing a winning outcome for both the patient family and also the public at large. Non-institutional programs that restore not only a patient, but the family back to maximum functioning will reduce the overall cost of the system. I think the system should be approached by producing a positive return on our health care investment. We have to look at this in terms of an investment in many ways. Fundamentally, we believe that the return on our health care investment results from restoration of a patient/family unit back to functioning as opposed to subsidizing the cost of institutional care. The catastrophe as we see it, is in designing a system which promotes dependence on the system as opposed to returning people to useful and productive lives.

So how do we design a system like this? I think one of the things we should do is build on the progress we have already made. From a practical point of view, a catastrophic health plan doesn't need to be built a-new, but rather should improve upon and eliminate the

obstacles to the many and creative and cost-effective systems that currently exist. There are examples of such programs taking place across the Nation, where they can maintain a patient in the home at 50 percent of the cost that would be incurred if the patient were placed in a nursing home. Perhaps those programs could be the foundation upon which we can develop a truly meaningful and cost effective delivery system.

Right here in Alabama, our VNA, working with our area agency on aging, has used the concept of case management and home based services to keep people in their homes and out of institutions. This approach isn't very unique, but it is very practical in maximizing the care of patients and minimizing the cost of the patient on the system. Over the past year, for instance, our community based Medicaid waiver program has kept 144 individuals out of the nursing home at a cost of less than $500 a month.

There are some problems we need to overcome first. One, which has already been mentioned, is the need to close the widening gaps in our current acute health care system before they become catastrophic in themselves. The U.S. General Accounting Office on January 10th of this year issued a report which shows that Medicare beneficiaries are currently being deprived of the services that they need and to which they were originally intended to receive. GAO states in its report that Medicare beneficiaries are not receiving the home care benefits to which they are entitled because the Department of Health and Human Services and its contractors, the intermediaries, have applied the rules too stringently.

We must address the fact that beneficiaries are currently not receiving coverage that Congress had intended for them to receive. And I think you have heard some of that today. These gaps in the system, as we call them, particularly, affect me as a home health care provider. For instance, we now operate on a cost/minus system and we struggle with reduced cost limits, increased denials, restrictive and conflicting interpretation of Medicare regulations, delayed payments and increasingly costly paperwork. I think Dr. Goldstein already mentioned that with respect to denials of payment to providers.

Although Medicare claims to have made no change in home health care benefits, these problems, in effect, restrict a provider's ability to render the service, thereby, restricting care to their clients in the Medicare and Medicaid Programs.

It seems that at the same time the Medicare prospective payment system (the DRG's) has pushed patients out of hospitals in a "quicker and sicker" mode—Medicare is depriving its beneficiaries of their only alternative—home health services. As one spokesperson put it in previous testimony, "patients are now being discharged from the hospital and into oblivion."

I think one of the things we need to do also, Senator, is to remove the obstacles and disincentives to using multiple funding sources to create effective and innovative forms of health care. The ability to combine or offer multiple sources of funding enable the health care provider to offer the necessary continuum of care you have heard about today. This continuum will ensure that the patient receives no more and no less service than they really need.

You might be surprised to find out that Medicare certified agencies such as the VNA are penalized for providing cost based grant programs to our communities. The cost finding procedures that Medicare uses to allocate or, in my opinion, misallocate, overhead to non-Medicare departments cost our agency $32,000 last year.

For instance, the Medicaid waiver program we have mentioned earlier cost my agency an additional $24,000 in misallocated overhead due to the Medicare costing procedures.

There is very little motivation for an agency to seek community dollars to provide supportive services such as those which have proven so helpful as mentioned earlier in my testimony. To me this seems pennywise and pound foolish. We are able to maintain individuals in their homes, and it costs less than half of what it would be for institutionalization.

Without these programs, specifically, Medicaid waivered services and homemaker services (through the Older Americans Act), these individuals have few options, if any, other than direct institutionalization or abandonment, which has also occurred. This would be catastrophic indeed.

I think we should re-direct our spending priorities before we reach the point of no return. The wave of our growing number of older Americans will fit our Nation with unyielding force within the next three decades. We don't have a whole lot of time to waste.

Health care needs brought on by environmental factors, cancer, AIDS and debilitating diseases such as Alzheimer's disease will consume disproportionate and catastrophic economic resources. Yet, the amount of funding allocated to Alzheimer's disease, for instance, is equal to what this country spends on one B–1 bomber.

Catastrophes may be avoided, not only by developing an effective system of sickness related reimbursement, but also by directing funds toward research and prevention of such devastating illness.

In summary, I think that a catastrophic health insurance plan for Americans should: (1) Approach the issue as a return on our health care investment by restoring or maximizing the potential of patients for independent living through the use of home health care, community based alternatives and supportive services. (2) Build on the progress that we have already made in less costly, non-institutional care models. (3) See the wisdom in structuring a continuum of care by first closing the gaps in the current acute care system before it undermines the total system. (4) Remove obstacles and disincentives to using multiple funding sources to establish creative and innovative forms of health care. (5) Re-direct our spending priorities so that solutions maybe found while they still may be achievable.

I appreciate the opportunity to speak on behalf of community based and home health care providers.

[The prepared statement of Ms. Hermanson follows:]

TESTIMONY OF KAREN HERMANSON

BEFORE THE FIELD HEARING OF THE U.S.SENATE

SPECIAL COMMITTEE ON AGING

APRIL 16, 1987

U. S. COURTHOUSE - BIRMINGHAM, ALABAMA

"THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE"

We commend Secretary Bowen and the Administration for the great strides they have taken to initiate solutions for those who will become victims of catastrophic illness. I have read the Bowen plan, as well as the testimony held in the joint House and Senate Committee hearings earlier this year and I have studied and reviewed articles to get a sense of public reaction. The complexity of this issue is revealed in the diversity of opinions, solutions and questions generated. Realizing this complexity, I hope to approach this matter from the viewpoint of those of us in the healthcare system who actually provide care for victims and their families who have suffered a catastrophic illness.

FOCUS ON COST EFFECTIVE, NON INSTITUTIONAL PROGRAMS TO RESTORE PATIENTS AND THEIR FAMILIES TO MAXIMUM FUNCTIONING

The approach to the system should be structured to focus on positive financial and societal outcomes necessary to produce a positive return on our health care investment. Fundamentally, we believe that the return on our health care investment results from the restoration of a patient and family to health and independence--not in the extension of costly institutional care. The catastrophy, as we see it, is in not providing a means for people to gain their maximum potential for returning to the mainstream of life. The system should produce a win/win outcome, both for the patient/family and also the public at large.

BUILD ON THE PROGRESS WE HAVE ALREADY MADE

From a practical point of view, a catastrophic health plan should not build anew, but rather improve upon and eliminate obstacles to the many creative and cost effective systems which currently exist. There are examples of such programs taking place across our nation. Perhaps these programs should be the grass roots upon which we can develop a foundation for a truly meaningful and cost effective health care delivery system.

New York's Nursing Home Without Walls Program has shown that a patient can be maintained in the home at 50% of the cost that would be incurred if the patient were placed in a nursing home. Right here in Alabama our agency, working with our Area Agency on Aging, has used the concept of case management and home based services to keep the frail and categorically needy in their homes and out of institutions. This approach is not unique, but has been practical in maximizing the care and minimizing the cost of people who otherwise would be institutionalized at greater and catastrophic expense. Over the past year, our community based Medicaid Waiver Program has been able to keep 144 individuals out of nursing homes

BUILD ON THE PROGRESS WE HAVE ALREADY MADE (continued)
by providing case management, home makers, personal care, respite care, day care and housekeeping services to clients at an average cost per case of under $400 per month. Although these services are not considered to be skilled in nature, in comparison to a $1,400 average cost per month for nursing home care. this alternative represents a significant return on our health care investment.

CLOSE THE WIDENING GAPS IN OUR CURRENT ACUTE HEALTH CARE SYSTEM BEFORE THEY BECOME CATASTROPHIC IN THEMSELVES
The U. S. General Accounting Office on January 10, 1987, issued a report which shows that Medicare beneficiaries are being deprived of the services that they need and to which they were originally intended to receive. GAO states in its report that Medicare beneficiaries are not receiving the home care benefits to which they are entitled because HHS and its contractors, the intermediaries. have applied the rules too stringently. We must address the fact that beneficiaries are currently not receiving the coverage that Congress had intended for them to receive. This coverage has been eroded to the point that it is undermining the current Medicare program. Medicare home health providers who now operate on a "cost minus" system struggle with reduced cost limits, increased denials, restrictive and conflicting interpretation of Medicare regulations, delayed payments and increasingly costly paperwork. Although Medicare claims to have made no change in the home health benefit, these problems in effect restrict a provider's ability to render the services. At the same time that the Medicare prospective payment system (DRG's) has pushed patients out of hospitals in a "quicker and sicker" mode, Medicare is depriving its beneficiaries of their only alternative. As one spokesperson put it, "the patients are now being discharged from the hospital into oblivion".

REMOVE OBSTACLES AND DISINCENTIVES TO USE MULTIPLE FUNDING SOURCES TO ESTABLISH CREATIVE AND INNOVATIVE FORMS OF HEALTH CARE
The ability to combine or offer multiple programs enables health care providers to offer a continuum of health care services. This insures that patients receive no more or no less service than they actually need. Most of you will be surprised that agencies such as the VNA are penalized for providing cost based entitlement programs to our communities. The cost finding procedures Medicare uses to allocate (or in this case, misallocate) overhead to non Medicare departments cost our agency $32,000 in 1986. There is very little motivation for an agency to seek community or entitlement dollars to provide supportive services such as those which have proven so helpful as mentioned earlier in my testimony. To me this seems penny wise and pound foolish. We are able to maintain individuals in their homes and it costs less than half of what it would be for a nursing home. Without these programs, specifically Medicaid Waivered Services and Home Maker Services through the Older Americans Act, these individuals would have few options, if any, other than direct institutionalization or abandonment. This would be catastrophic indeed.

REDIRECT OUR SPENDING PRIORITIES BEFORE WE REACH THE POINT OF NO RETURN

The wave of our growing number of older Americans will hit our nation with unyielding force within the next three decades. We do not have much time to waste. Health care needs brought on by environmental factors, cancer, AIDS and debilitating diseases, such as Alzheimer's disease, will consume disproportionate and catastrophic economic resources. Yet the amount of funding allocated to Alzheimer's disease, for instance, is equal to what this country spends to buy one B-1 bomber. Catastrophe may be avoided not only by developing an effective system of sickness related reimbursement, but also by directing funds toward research and prevention of such devastating illnesses.

In summary, the catastrophic health insurance plan for Americans should:

1) Approach the issue as a return on our health care investment by focusing on restoring and/or maximizing the potential of patients for independent living through the use of home health care, community based alternatives and supportive services.
2) Build on the progress that has been made in our health care system, especially those less costly, non institutional alternative care modes.
3) See the wisdom in structuring a continuum of care by first closing the gaps in the current acute care programs before they undermine the total system.
4) Remove obstacles and disincentives to use multiple funding sources to establish creative and innovative forms of health care.
5) Redirect our spending priorities so that solutions may be found while they still may be achievable.

We appreciate the opportunity to speak on behalf of community based and home health services and express our gratitude to those who solicit public response regarding catastrophic health insurance.

Senator SHELBY. Mr. Bolen, you may proceed.

STATEMENT OF JOSEPH BOLEN, VICE PRESIDENT OF PROVIDER AFFAIRS, BLUE CROSS AND BLUE SHIELD OF ALABAMA

Mr. BOLEN. Thank you, Senator Shelby. I appreciate the kind remarks you made previously and I am honored that you invited me here today.

I am Joe Bolen, vice president of Provider Affairs for Blue Cross and Blue Shield of Alabama. I appreciate the opportunity to testify on catastrophic health care coverage. And we also share your concerns about America's and Alabama's families from financial ruin of catastrophic health care.

Most Americans who are confronted by high medical bills are somewhat cushioned against the full financial impact of these expenses by private insurance or public programs such as Medicare and Medicaid. However, we understand that a large number of people do not have such coverage. Even people who have health care coverage can be confronted by catastrophic health care bills for services that are not covered or because there are expenses that exhaust their benefit. Although catastrophic illnesses affect all age groups, my comments will be limited to protecting the elderly from financial catastrophic health care cost.

The elderly constitute in the population group the greatest risk of incurring high health expenses. And instances of acute and chronic illness is high among the elderly. They have the highest instance of large medical expenses of any age group. Medicare provides basic coverage, but is limited with regard to coverage of nursing home care, long hospital stays, and physician coverage. Given that many of the elderly have relatively low fixed incomes, large out-of-pocket medical expenses places a severe burden on them and their family. The Medicare Program, at best, does not provide full comprehensive protection against cost resulting from acute and chronic illness. For acute illness the Medicare Program leaves the beneficiary liable for substantial deductibles, co-payments on coverage services, and for a wide range of noncovered services such as prescription drugs. For long-term care, the Medicare Program essentially provides no coverage. The benefit of limitations of the Medicare Program places beneficiaries at a risk for catastrophic expenses. The need of the elderly for more comprehensive protection is apparent.

We feel that private insurance such as medigap policies do provide somewhat of a cushion for acute care illnesses. They provide a supplement to the traditional Medicare policies. However, they do not address the long-term care aspect.

We also realize that there is a gap for the low income elderly, the one that cannot afford medigap policies, and this is a problem that they are faced with in acute care catastrophic illnesses because they do not have medigap type policies. As I mentioned previously, the biggest gap we see is in long-term care coverage while Medicare and medigap provide the elderly with reasonable protection from catastrophic acute care expenses. Long-term care is the elderly's largest single out-of-pocket health care expense.

There is a proposal in Congress now to incorporate catastrophic coverage with Medicare. We feel this is a good first step in looking at acute care catastrophic insurance. We would support this approach if the program is designed so that the funding mechanism does not create a burden on the low income beneficiary. Also we feel that with this proposal in the Congress there needs to be a special effort to be made in the area of beneficiary education to avoid the confusion about the program. I think we're all aware that there is so much confusion now that exists with the Medicare and medigap policies about what is covered and not covered. We feel the Congress should look at this and we should work together with the local senior citizen agencies, churches, State and Federal Governments to explain what Medicare covers and does not cover in this new catastrophic plan.

It would not, necessarily, replace the medigap policy. We think that it would be a disservice to the elderly if they felt that the new catastrophic plan in Congress would replace the medigap coverage.

In conclusion, we do feel that Blue Cross and Blue Shield and the medigap policy does provide protection in acute catastrophic care. There are other medigap policies that we feel also provide sufficient coverage in this respect. However, we do realize that there is 30 or 40 percent of the population that cannot afford medigap coverage and this needs to be addressed to somehow providing assistance for the purchase of some type of medigap gap coverage for these type people. Also we feel that if Congress should incorporate catastrophic benefits into the Medicare Program and should not burden the cost on the low income elderly, then we will support such a program.

In regards to long-term care, we feel that private long-term insurance can provide a system in which all parties would benefit. Although the problem of protecting the elderly in catastrophic cost is difficult and complex, we feel, that through a combined effort of the public and the private sectors, solutions can be found. We look forward to working with you Senator Shelby, thank you.

[The prepared statement of Mr. Bolen follows:]

TESTIMONY OF JOE BOLEN

VICE PRESIDENT OF PROVIDER AFFAIRS

BLUE CROSS AND BLUE SHIELD OF ALABAMA

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ON

CATASTROPHIC HEALTH CARE COVERAGE

April 16, 1987

Mr. Chairman, I am Joe Bolen, Vice President of Provider Affairs of Blue Cross and Blue Shield of Alabama. I appreciate this opportunity to testify on catastrophic health care coverage and share your concern about protecting America's and Alabama's families from the financial ruin of catastrophic health care cost.

Most Americans who are confronted by high medical bills are cushioned against the full financial impact of these expenses by private insurance or public programs such as Medicare and Medicaid. A large number of people, however, don't have such coverage. Even people who have health care coverage can be confronted by catastrophic health care bills for services that are not covered or because their expenses exhaust their benefits. Although catastrophic illness affects all age groups, my comments will be limited to protecting the elderly from financially catastrophic health cost.

The elderly constitute the population group at greatest risk of incurring high health expenses. The incidence of acute and chronic illness is high among the elderly and they have the highest incidence of large medical expenses of any age group. Medicare provides good basic coverage, but is limited with regard to coverage for nursing home care, long hospital stays, and physician coverage. Given that many of the elderly have relatively low fixed incomes, large out-of-pocket medical expenses can place a severe burden on them and their families.

The Medicare program at present does not provide full comprehensive protection against costs resulting from acute or chronic illness. For acute illnesses, the Medicare program leaves beneficiaries liable for substantial deductibles and copayments on covered services, and for a wide range of non-covered services, such as prescription drugs.

For long term care, the Medicare program essentially provides no coverage.

The benefit limitations of the Medicare program places beneficiaries at risk for catastrophic expenses. The need of the elderly for more comprehensive protection is apparent.

Private Insurance Protects Most Elderly from Acute Care Catastrophic Expense

Blue Cross and Blue Shield of Alabama believes that the private market has functioned well in providing protection against major financial loss for acute care expenses of the majority of Medicare beneficiaries. Most Medicare beneficiaries are protected against excessive out-of-pocket costs for hospital and physician care by private coverage which supplements Medicare benefits - Medigap.

A Major Catastrophic Acute Care Coverage Gap-Low Income Elderly Without Supplemental Coverage

While we believe that the Medigap program offered by Blue Cross and Blue Shield of Alabama and by some other companies is a "good buy" for most beneficiaries, there are people who cannot afford this coverage. Most of the beneficiaries without supplemental coverage say that they simply cannot afford it. This has been confirmed by a Congressional Budget Office analysis showing that low income beneficiaries are the ones most likely to lack supplemental coverage. Thus, a major coverage gap by Medicare, Medicaid, and private Medigap programs is the failure to provide adequate coverage of acute care expenses for the low income elderly.

Long Term Care - Another Gap

The largest health care coverage gap for the elderly is the lack of adequate protection for long term care. While Medicare and Medigap provide the elderly with reasonable protection from catastrophic acute care expenses, long term care is the elderly's largest single out-of-pocket health expense.

Recommended Solutions

The escalating cost of medical care is putting more and more families at risk for large out-of-pocket expenses. The cost of health care has increased at a faster pace than has the cost of all other goods and services. Cost containment techniques to keep the Medicare program

solvent must be employed. Unless health care cost can be contained, medical care coverage will not be affordable, either by government or private sources for millions of Americans.

Recently, Medicare beneficiaries were permitted to opt out of traditional Medicare coverage and join private Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs). These plans operate on a capitated, or "so-much-per-patient" basis. When a Medicare beneficiary enrolls in such a plan, Medicare pays the Plan an amount equivalent to 95% of what Medicare would have spent on behalf of that individual had he or she remained under standard Medicare.

In exchange for this payment, the Plan must provide its members with the basic services covered by Medicare. If it can provide those services for less than the 95% of the amount, it earns a surplus that it must share with the enrollees - either in extra benefits or in reduced cost sharing. If it can't, it must absorb the loss.

Many HMOs and CMPs are more comprehensive than Medicare. With an HMO or CMP the deductible and copayment amounts are generally much smaller than with Medicare or even may be nonexistent. Many such Plans offer extra benefits such as eye exams and prescription drugs, which also are not covered by Medicare.

Understandably, many beneficiaries find CMPs and HMOs appealing. They offer convenient, comprehensive, "one-stop" health care coverage, which they cannot get through Medicare.

Incorporating Catastrophic Coverage into Medicare

It has recently been proposed to incorporate acute care catastrophic insurance protection into the Medicare program. We support this approach if:

1. the program is designed so that the funding mechanism does not create a burden on the low income beneficiaries;

2. a special effort be made in the area of beneficiary education to avoid confusion about the program benefits.

In regard to the financing mechanism for such a new benefit, we recommend against taxing a portion of the actuarial value of Medicare benefits. We urge you to explore other options that would protect the low income beneficiaries from the cost of such a benefit. Such alternative financing mechanisms include:

1. an income related premium surcharge added to the tax liability of beneficiaries who must file tax returns;

2. scaling out-of-pocket expense limits to the beneficiaries' income or ability to pay.

Beneficiary Education

Legislation to create such a benefit will result in some beneficiary confusion. Studies indicate that many Medicare beneficiaries presently feel that the Medicare benefits are greater than they actually are. We are concerned that such a new program may give beneficiaries an additional false sense of security that could lead them to drop private coverage for the remaining acute care coverage gaps and discourage public interest in long term care protection. A special effort will be required by all concerned to minimize beneficiary confusion over any new legislation for catastrophic cost protection.

Effect of CMPs and HMOs

The effect that such a program may have on the development and growth of alternate delivery systems should also be considered. If consumers mistakenly feel that this new benefit provides complete or comprehensive protection against the cost of acute illness, they may be disinterested in comprehensive benefits that most HMOs or CMPs offer. If such a benefit impedes the growth of Medicare CMP or HMO enrollment, incentives for joining alternative delivery systems should be explored by the Congress. If a catastrophic benefit is added, capitation payments to HMOs and CMPs must be adjusted upward to reflect the estimated costs of such a benefit.

Long Term Care

The largest coverage gap in protection against catastrophic health care cost is long term care. This problem has been intensified due to the effort to reduce length of stay in the acute hospital care setting.

Most payment for acute care is covered through Medicare, Medicaid, and private insurance, leaving out-of-pocket expenditures an almost insignificant source. In contrast, however, nearly one-half of all nursing home expenditures are paid from personal resources, Medicaid pays nearly all of the rest.

A common misconception among the elderly and the public is that payment for nursing home care is covered by Medicare. Medicare pays for only about 2% of all nursing home care. This is due to the extremely restrictive conditions for qualification and the limited number of nursing home beds certified by Medicare.

Nursing home bills, upwards of $22,000 per year, can quickly deplete savings and home equity. Many nursing home patients originally enter these facilities as private pay patients, quickly exhaust their personal financial resources, and then qualify for Medicaid coverage.

Education in the area of Medicare and Medicaid benefits regarding long term care should be intensified. The elderly need to realize that Medicare and supplemental insurance do not cover long term care. Also, the elderly must understand the financial implications of an extended nursing home stay.

The public's perception that the government will assume the costs for long term care must be changed. Individuals should be encouraged to assume more responsibility for their own potential risks of needing long term care services.

Given that Medicare and Medicaid are not likely to incur greater portions of long term care expenditures, long term care insurance appears to be a solution to the problem. Blue Cross and Blue Shield of Alabama is developing such a long term insurance product to assist in this area by combining Home Care and Nursing Home Care on a service basis to a Life Insurance product to attract the younger population to the Program. This will allow long term funding and interest compounding to provide a meaningful benefit. It is hoped that both the state and federal government will lend support in our effort to offer this product to the citizens of Alabama.

Providers, insurers, consumers, and government payers would benefit from the availability of long term insurance.

Conclusion

In conclusion, Blue Cross and Blue Shield of Alabama believes we have functioned well in providing acute health care protection against major financial loss for many of Alabama's Medicare beneficiaries through our Medicare supplemental insurance program. We recognize that there is a segment of the population which simply cannot afford this private protection. Therefore, we would urge you to consider methods of special financial assistance for the purchase of private coverage.

All third party payers must continue in their efforts to contain the rapidly escalating cost of health care through utilization review, preadmission certification processes, and other programs. Unless health care cost can be contained at a reasonable level, adequate health care coverage will be too expensive for government, private business, and individuals to purchase.

If catastrophic benefits are incorporated in the Medicare program, and the low income elderly are not burdened with the cost of such a program, we would support such legislation.

In regard to long term care, we feel that private long term insurance can provide a system in which all involved parties would benefit.

Although the problem of protecting the elderly from catastrophic cost is difficult and complex, we feel that through a combined effort of the public and private sectors, solutions can be found. Blue Cross and Blue Shield of Alabama looks forward to working with you on this most important issue. I appreciate the opportunity to share our views with you.

Senator SHELBY. I thank all of you.

Dr. Goldstein, how many of your patients supplement their Medicare coverage with private supplemental insurance or a medigap plan in your best judgment?

Dr. GOLDSTEIN. In my best judgment, probably, 85 to 90 percent of them.

Senator SHELBY. 85 to 90 percent?

Dr. GOLDSTEIN. Yes.

Senator SHELBY. Do you find that a lot of your patients are cognizant to what is and what is not covered under their plans?

Dr. GOLDSTEIN. Oh, they're not. I can tell you right now, I'm not aware of what's covered. In fact, in this folder I keep with me all the time what Medicare benefits are. I can't keep track of what all of the——

Senator SHELBY. And you're a practicing physician dealing with it everyday?

Dr. GOLDSTEIN. If I didn't have the ladies in the insurance department I would be in major trouble.

Senator SHELBY. Dr. Goldstein, since you're the physician at the panel, I'm directing a few questions to you. What has been your experience on home health care? Do you find that quality of service of both home health care agencies and nursing home facilities to be okay, to be mediocre, to be improved? I would like to have your judgment.

Dr. GOLDSTEIN. You have hit my favorite topic and I appreciate that. In general, we have had good results with home health care agencies. The problem that I find is that I don't have any contact directly with the individual, in most cases, going out to see my patient. I have no idea whether the individual has a lot of qualifications, no qualifications, whether they understand exactly what I want done. I get phone calls regularly. Most of the phone calls are from the nurses who visited the patient and are very appropriate. I get good information. Occasionally I don't, but I think that is true of any system. I think there is a major lack in the system, that of not working together. There is no continuum of the acute care patient who is seen by social service discharge planning, hospice nurse or whatever it happens to be in the hospital, and then the continuum of the home health agency and then rehab, et cetera, et cetera. One of the concerns I have is there is some rumor now that we may be getting ready to see third party carriers drop financial support for rehab. That would be a disaster. We might as well just not let people go on home who are chronically ill because they cannot be taken care of at home. The restrictive rules at home are terrible. We had one patient who couldn't get dialysis because if she left the house to get her dialysis she wasn't homebound. If she was homebound she could get her nursing care.

Senator SHELBY. Those are ridiculous rules, aren't they?

Dr. GOLDSTEIN. That's right. And the rules are restrictive and some of the problem, and I mean this with all sincerity. Laws are passed, somebody writes rules and regulations and down the line somebody interprets those.

Senator SHELBY. That's right.

Dr. GOLDSTEIN. And in my experience recently so many interpretations have been less than acceptable. And Joe and I talk a lot

and write letters to each other a lot and have some debates that I think both of us are trying to obtain the same thing.

Senator SHELBY. What we're really wanting is the system to work, isn't it?

Dr. GOLDSTEIN. That's correct.

Senator SHELBY. Doctor, one last question. In your opinion, do you believe that patients do better physically, mentally, and spiritually at home receiving home care or in a nursing home?

Dr. GOLDSTEIN. Well, I think that is easy from the standpoint of the patients I care for and what happened to my parents. People want to be in their own home. My mother took on a giant bill for herself just to have the privilege, and that's what she calls it, a privilege of dying in her own bed because she knew the illness that she had could not be cured. And she approached death in a very dignified way and she taught me a lot in her illness. And I apply that everyday to the patients that I see. People don't want to be in nursing homes, it takes away the dignity that you and I live with everyday.

Senator SHELBY. Thank you. Mrs. Friedlander, as you're very aware, Medicare's Prospective Payment System, PPS, provides an incentive for hospitals to release patients sooner than was the case under the old open-ended reimbursement system. It's not always bad that this is true, as long as we have adequate and quality post-hospital services available. You're involved in this. However, since the enactment of the Prospective Payment System, hospital discharges have increased by 37 percent, but the growth of home health services since then has slowed. In January 1987, the General Accounting Office, the watchdog for Congress, surveyed hospital discharge planners, and found that 97 percent of 850 of the Nation's hospitals discharge planners, are having problems placing Medicare patients in skilled nursing facilities. And 86 percent of this group reported problems with some home health care placement. According to the report and I quote "Medicare program rules and regulations were cited as the most important barrier to placing Medicare patients in both skilled nursing facilities and home health care." Do you agree with that?

Mrs. FRIEDLANDER. Definitely. Thank you for saying it.

Senator SHELBY. That's what Dr. Goldstein is also saying. Do you agree with that?

Ms. HERMANSON. I certainly do.

Senator SHELBY. What about you Mr. Bolen?

Mr. BOLEN. Yes.

Senator SHELBY. And you're dealing with this—you as a practicing physician are dealing everyday—you're dealing at the hospital, you're dealing with a nursing aspect and you're dealing as provider, are you not, in every aspect of health care?

Mr. BOLEN. Yes.

Senator SHELBY. So like Dr. Goldstein pointed out, oftentimes it's the interpretation of the laws and/or regulations that cause more trouble than anything, isn't it?

Mr. BOLEN. Yes, sir.

Senator SHELBY. If you had a one priority and you could sum it up in just a minute, each one of you, what would your priority be? You have heard the witnesses. We have got to have a comprehen-

sive approach. And yet, all the elderly don't need the same thing. What would you recommend to this committee that we do?

Mr. Bolen, we'll take you. Since you have been coming last, we'll take you first.

Mr. BOLEN. The first thing I would recommend to the committee is we need to spend more time on education of the beneficiary about exactly what they have. There is just so much confusion about when they go to the physician or to the hospital. They think everything is covered and it's not and there is some misinterpretation there.

So my main priority at this point is to somehow, through the different agencies available, try to make them understand exactly what they have and need at a early age in life so they won't be faced with uncovered expenses such as long-term care.

Senator SHELBY. And that's the dissemination of information and that's hard.

Mr. BOLEN. Yes. It's real hard, I realize.

Senator SHELBY. Mrs. Friedlander, what is your No. 1 priority.

Mrs. FRIEDLANDER. I think if I had just one thing to emphasize it would be that the committee please consider the issue of long-term care; that it is not the bottomless pit that so many people seem to think it is. We have already heard today from people who have explained that a continuum of care is so critical for our patients. If we can work on developing and ensuring community and home-based support services, we can save money in the long run, and the care that the elderly need in order to remain in their homes and communities can be provided in a cost effective manner.

Senator SHELBY. Thank you. Dr. Goldstein.

Dr. GOLDSTEIN. I would like to see a system that looks at cost wise, efficient care of people and not based on budgetary restraint or the GNP.

Senator SHELBY. Ms. Hermanson.

Ms. HERMANSON. What Mrs. Friedlander said is what I would say. In addition, we need to identify the current problems in our system such as Medicare restrictions on home health care. There are barriers to providing care now in our current acute care systems which need to be rectified before we add on more problems. So I would like to cite Beverly and fix the current system and then add on to it so that it all makes sense.

Senator SHELBY. I want to thank this panel particularly, the last panel, for appearing here, taking off from your schedules and your various professions to add your testimony and your experiences to this field hearing.

And I also want to thank the other people that preceded you here today. And lastly, I want to thank all of you that came to the hearing because you're concerned about health care in America and, particularly, catastrophic health care.

This is, I believe, good for me and it was good for Senator Heflin and I wished he could have stayed, but he couldn't do that, he had a busy schedule.

I am going to take this testimony and it will be a part of the field hearing record on this issue and it will help me better understand the problem. I think if we had more field hearings in the United States from Members of the House and Members of the Senate, it

would give us a firsthand appreciation of the real problems and, perhaps, how to solve them. I think we need to come home more often and learn something.

Thank you again, everybody.

[Senator Shelby would like to make his concluding statement a part of the hearing record at this point:]

CLOSING STATEMENT BY SENATOR RICHARD SHELBY

Thank you all for being here this morning and for giving of your time and your expertise. I thank the victims, who have told their stories straight from the heart. As they say, nothing speaks like experience. I thank the advocates: from AARP, NARFE, Jefferson County Office of Senior Citizens and Focus On Senior Citizens, who give of their time each day to see to it that the needs and comforts of thousands of Alabama's older citizens are met. I thank Dr. Bridgers and Dr. Schnaper of UAB, for sharing with us their knowledge acquired after many, many long days and nights of dedicated research. And finally, thank you to our providers: Dr. Goldstein, Mrs. Friedlander, Ms. Hermanson and Mr. Bolen, for their hands on and realistic approach to this issue.

Today, we have learned that there are some very serious gaps in the health care coverage of the Medicare program. These gaps leave the elderly susceptible to the devastation of catastrophic illness. Added to that problem, we know that, at any given time, over 30 million Americans under age 65 are without health insurance. If we, in Congress, can work together with the private sector on many of the ideas we discussed today, I believe we will be able to formulate a catastrophic illness plan that will make all of us proud. Thank you all again for assisting us in reaching our goal.

The official record for this hearing will be kept open until the 30th of April for any additional written testimony. This field hearing is hereby adjourned.

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1

ALABAMA STATE CHIROPRACTIC ASSOCIATION

134 High Street
Montgomery, Alabama 36104
(205) 262-2228

April 16, 1987

The Honorable Richard Shelby
516 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Shelby,

On behalf of the Alabama State Chiropractic Association may I express our appreciation for your kind invitation to be apart of your first hearing for the United States Senate Special Committee on Aging in Birmingham.

Enclosed are some thoughts on the issue of Catastrophic Health Care Coverage. Hopefully, they will high-light problems of the aging as well as expand your pool of information on the issue.

Thank you for allowing us to be a part of this hearing.

Sincerely,

P. Reginald Hug, D.C.
National Legislative Chairman
P. O. Box 43547
Birmingham, Al 35243

CLYDE L. SHOWN, D.C. PRESIDENT
RICHARD COOK, D.C. CHAIRMAN OF THE BOARD
MARGARET BAKER, D.C. SECRETARY-TREASURER
HAROLD PIERCE, D.C. PARLIAMENTARIAN
WILLIAM D. GODBEY, D.C. TRUSTEE
JOHN R. PEACOCK, D.C. TRUSTEE
P. REGINALD HUG, D.C. TRUSTEE

* At retirement, most Americans now face what amounts to a whole new generations of life. A man turning 65 can look forward on average to 15 more years; a woman 19 more years.

* Since 1900, life expectancy at birth has gained 26 years, almost as much as had been accumulated in the preceding 5,000 years.

* Five of those years are attributable to reduced death rates in those over 65.

* Hence, the Longevity Revolution -- causing major social and political shifts.

* If present trends continue, the number of elderly will double to about 60 million by the year 2020.

* Though the poverty rate for the elderly has dropped in the last 20 years, many more are considered economically vulnerable. But, still, there are many more children in poverty than there are elderly Americans. This sets up a possible future conflict between generations.

* People over 85 are one of the fastest growing segments of the population -- the group amount the elderly which tends to be the sickest and the poorest.

* A recent HHS survey of Medicare beneficiaries found that between 17% and 33% of elderly Americans have more that one health insurance policy to supplement Medicare coverage.

* Although as many as 1/3 of the elderly purchase Medigap policies, the government cannot determine whether the coverage is duplicative or complementary.

* Consumer knowledge of insurance benefits varies according to frequency of use. Although knowledge of physician office visit benefits was high, knowledge of skilled nursing coverage was low.

* Less than half understood what was covered when it came to skilled nursing facilities or custodial care, but more than half understood prescription drug and Part B coinsurance requirements.

* HHS says it "sees no need" for federal oversight of Medigap policies, preferring state regulation instead. HHS says states can improve beneficiary understanding by setting minimum benefit standards and loss ratios, dispensing buyers' guides, requiring labelling of non-Medicare supplemental policies, and by publicizing incidents in which companies

agents are found guilty of misconduct.

* As creatures of state licensing procedures, chiropractic physician have always relied upon state regulation and have successfully looked to state regulation and state legislative initiatives to guarantee state equality.

* This system has worked admirably for many decades.

* The system was frustrated to a very large degree by the Employee Retirement Income Security Act of 1974, and ERISA's preemption of state insurance regulatory law.

* Where the states have fought to provide a degree of freedom of choice of health care provider to all insurance beneficiaries, ERISA preempts these state laws as well as state mandated benefit laws, and offers no such commensurate protection through federal regulatory mechanisms.

* Therefore, the Chiropractic profession looks with some skepticism at a federal effort or oversight of insurance policies -- be they Medicap or any other type of policy. This is particulary true if it means tinkering with state law-making authority -- through preemption by federal law. Although well-meaning in a search for national uniformity, federal action in this regard too often neglects the complexities involved with federal preemption of state laws and fails to see the full ramification of its effort -- again, witness the ERISA preemptions.

* Certainly, we believe there should be some uniformity from state to state in the minimum requirements a state should impose -- and perhaps therein lies the federal role -- but oversight and regulation of insurance should remain within the province of the several states.

* Whether we are talking about Medicare, Medigap coverage, federal employee health-care coverage, catastrophic and/or long-term care coverage, the federal government should be the first to encourage, through legislation and regulation, the tenets of freedom of choice -- a beneficiary's right to choose who will provide health-care services to that patients.

* The Social Security Act providing for the basic Medicare system provides for Medicare beneficiaries freedom to choose the physician of choice. (Section 1802, SSA - "Freedom by Patient Guaranteed. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title of such institution, agency, or person undertakes to provide him such service.")

* Unfortunately, as it pertains to the services of several physician providers, limitations of Medicare coverage frustrates the real goal of freedom of choice. Medicare does not provide for full-service reimbursement for the services of many licensed health-care providers; this is an economic barrier to the beneficiary which dilutes his or her real freedom to choose and negatively governs the patient's actions in seeking health care.

* Medicare reimbursement for chiropractic services, for instance, is limited to only one service!

* Chiropractic physicians are educated, trained and licensed to provide a wider range of health-care services, including adjunctive physiotherapy services, all without hospitalization or prescription drugs -- two of the real high cost items in the care of the elderly.

* The elderly do avail themselves of these non-covered services. Doctors of chiropractic treated 12 million patients in 1980, and of those, about 15.1% were estimated to be over 65 years of age. This cost Medicare only about $100 million.

* Those over 65 received chiropractic treatment over and above that reimbursed under Medicare. It was financed either by individual health benefits insurance or out-of-pocket expenditures. But is was demanded.

* Some elderly are unable to independently pay for the full treatment they need from a chiropractor, so they either don't receive it, or they go to a physician defined under Medicare as capable of receiving reimbursement for the required treatment. Although in most instances a chiropractor can provide the same services at a lower cost, because of financial restraints the elderly patient is forced to seek out more expensive care that can be reimbursed under Medicare.

* Reimbursing a patient for services rendered by one qualified class of physician and not for those rendered by an equally qualified alternative class of physician interferes with a patient's freedom of choice -- again, it is an economic disincentive to freedom of choice which stiffles health-care practitioner competition and leads to increased cost in health-care.

* Those disincentives need to be removed from law, by assuring that a Medicare and Medigap beneficiary may be reimbursed for diagnostic and treatment services for any particular condition covered by those public and private insurance policies when provided by any licensed physician of the patient's choice.

This allows the patient the options associated with being able to "shop around" for not only the highest quality of care, but care at a reasonable cost which is performed by a practitioner with whom the patient can feel at most ease -- a quality in elderly health care that cannot be overlooked.

* If a chiropractor can, under his or her specific state licensure law perform the services required to treat a condition, the chiropractic patient ought not be forced for economic reasons to seek those identical services from another physician who may be allow to receive reimbursement under the law.

* In addition, the laws need to be changed and standards set to prohibit situations where the federal government mandates dangerous and expensive diagnostic procedures -- as stipulations to further health-care treatment -- giving no discretion to the attending physician as to whether to employ the procedure and, most importantly, not reimbursing the patient for the federally-mandated diagnostic services.

* At present, Medicare law requires that a doctor of chiropractic take an x-ray of a Medicare beneficiary before further treatment may proceed. There is no consideration given to the advisability of such an x-ray -- its necessity or the impact of needless radiation on an elderly patient -- and the D.C. is given no flexibility to use alternative diagnostic measures -- in his or her judgment, for the benefit of the patient -- and does not take x-rays, such behavior jeopardizes his patient's reimbursement under Medicare.

* Such requirement impose on a physician's diagnostic and treatment protocol, and when the requirements are not reimbursed, they impose on the patient not only the risk of over- or needless exposure to radiation, but an increased financial burden, as well for the privilege of being exposed -- at the federal government's direction -- to the x-ray.

* The chiropractic x-ray requirement contained in law really is like an "admission fee" or "pool tax" for chiropractic services. The patient pays the admission fee -- through the non - reimbursable mandatory x-ray --(that may or may not be necessary for further treatment) before further treatment may even be considered. It's also akin to the government requiring Birmingham to build a new sewage treatment plant -- but not putting any federal funding toward the new facility's planning or construction.

* Public and private insurance do not take into adequate consideration the need for preventive health-care maintenance

and attention to nutrition, either.

* That portion of the elderly plagued with poor nutrition are also those least likely to be able to afford the type of services or counseling necessary to alleviate their plight.

* Good nutritional status not only keeps an elderly patient's health , it improves a patient's overall well-being and enhances the effectiveness of health-care treatment.

* Only 1% of all federal health dollars are spent on prevention. A small increase in this investment alone could save billions of dollars that ordinarily would be spent not only on the elderly, but on infants and children and all other segments of the national population as well. Poor Richard is not out of fashion -- an ounce of prevention is still worth a pound of cure. And where traditional medical care may not be geared to deal with "human preventive maintenance", it is nonetheless critical to present-day and future health -care requirements.

* The profile of our Nation's health -care needs has changed since Medicare was enacted in 1965. It is now as important to insure against the risk of chronic illness as that of acute illness.

* Although today's elderly, as a group, are significantly better off financially than their parents, and are expected to improve their financial situation even further over the next 25 years, the blows associated with long-term care concerns come at a time when the elderly are already paying significantly more out-of-pocket medical costs than their counterparts were when Medicare was first enacted. They are also plagued by a general acceptance today that one who is elderly must first ruin themselves financially by providing their own care before turning for public help.

* The Longevity Revolution has collided with a health care system geared to treat 40-year-olds.

* Older Americans may be the country's biggest consumer of medical services, but Medicare does not cover what some older people need the most: long-term care. About 1/3 of health care spending is for 12% of the population - those over 65.

* Although 80% of the elderly will never have to go to a nursing home, there is nonetheless a high lever anxiety among all the elderly as it relates to this possibility.

* Congress has its eyes on the wrong catastrophe. The real financial disaster that lurks for may older Americans lied not in hospitalization, but with long-term care -- the prolonged

care of the chronically ill in nursing homes or in their own home.

* "Trying to solve the catastrophic illness problem by better hospital coverage is like solving the cost of automobile accidents through better air-travel insurance." -- Dr. Robert L. Kane, Dean of the Univeristy of MN School of Public Health.

* The goal should be better coverage for long-term care that includes a full range of health and social services needed by people with chronic disabilities which impair their ability to perform basic tasks of daily living.

* Unless we are able to achieve greater continuity between acute and long-term care services, we will never have an effectively managed health-care system. For example, incomplete rehabilitation from an acute hospitalization may result in long-term dependency.

* Insurance coverage is often tied to institutional care and forces many people into a difficult choice -- moving into an institution versus little or no care at all.

* Coverage for home care under Medicare and Medicaid is quite limited and is tied to expenditures ordered by physicians for those on a clear path to recovery; coverage is more oriented to equipment and institutions than to custodial needs.

* The irony is that despite roughly $120 billion dollars per year in federal and state outlays for Medicare and Medicaid, they are often not there when you really need them. Those programs have always reflected a bias toward front-end coverage, with back-end exposure to unusually-high outlays; this is just the opposite of what insurance is supposed to do. And, the programs have always reflected a bias against care outside the institution. Finally, they originally also reflected a poorly-conceived cost-based reimbursement system. Here, at least, the federal government can point with pride to some real progress in recent years although there are battles left to be fought, as anyone who examines the way Medicare pays doctors realizes.

* Parenthetically for a moment on the topic of physician reimbursement. Public and private entities must keep in mind one inalterable fact. When it comes to patient treatment, the doctor is alone out there with his or her patient. Regardless of what the care costs in the minds of any entity -- public or private -- it is the physician who by ethics and legal requirements must afford the highest possible care to that patient, regardless of cost. With all due respect to peer review -- and that certainly is necessary to police any

profession from abuse -- it is the individual attending physician who must still make the calls and be able to live with him- or herself after all is said and done. It will continue to be very difficult to place the services of a physician within the constraints of cost-containment without the serious possibility of erosion in services. Afterall, physicians are human, too.

* While no one can certainly continue to allow health-care costs to increase at the rated they have in years past, those who look to contain costs cannot continue to look only to the physician as a means to that end.

* The government only mimicked the system it found in the private sector when it established Medicare and Medicaid. In fact, transporting that system, lock, stock, and barrel, from the world of private insurance into the new public programs was a part of the deal that brought them to life.

* Private insurance for long-term care is also quite limited; generally speaking, it rounds out and fills in what Medicare covers, but does not really complement Medicare and Medicaid in any meaningful sense. Private coverage mirrors public programs in many ways, adopting many of the same coverage restrictions found in the public sector. There is very little private coverage for home care, particulary of a custodial nature.

* Both public and private health coverage, then, are tied to the standard medical model and to health-care in an institutional setting. Yet, we know that increasingly the need is occurring outside of institutional setting and outside the traditional medical model. Of course we need standard medicine and basic research, but we also need much more emphasis on gerontology, social services, and support for families providing long- term care to a relative, and the alternatives to standard medicine available today to provide these services.

* Even a few weeks of visiting nurses, home health care, or paid companionship can amount to a sizable amount of money. Medicaid does not help until resources are totally dried up. And, many of these home care services, as noted earlier, are not covered by private insurance.

* Out of pocket expenditures for health-care accounted for 20 percent or more of annual income for an estimated 4.3 percent of all Americans, according to one estimate (Berki, Health Afairs, Winter 1986). But, among those with incomes below $12,000 a year, the corresponding figure was 8.7 percent, or twice as high. Indeed, according to the figures presented by Berki, based on the NEMCES Survey, 18.4 percent of those with

incomes equal to or below the federal poverty threshold spent 20 percent or more of their incomes on out-of-pocket medical expense. This is a stark reminder that catastrophic level medical expenses might be as "low" as $3,000 (not necessarily the $50,000 or $100,000 often depicted as the catastrophic problem) if the family's income is around the poverty line level.

* Ideally, Medicare should be expanded in a service-neutral approach, with the identification of services provided based on the elderly person's need rather than what Medicare will or will not pay for. If the federal government chooses instead to expand specific services, the focus should be on services needed to remain at home, recognizing the quasi-medical or non-medical nature of many of these services. Such services might be funded through the Social Services Block Grant and could include:

  -- meals
  -- personal hygiene
  -- assistance with intravenous feeding
  -- home safety to avoid accidents
  -- transportation to physicians'
  -- in short, assistance with daily living

* The Reagan Presidency, while not performing particularly spectacularly in the reduction of the Federal deficit, has instilled, nonetheless, a new concern for austerity and for knowing how we are going to pay for "new" or "expanded" federal programs.

* We have no magical ideas on how to pay for expanded coverage for the elderly, except to say that whatever mechanism is finally fashioned it must be predictable so that adequate planning can be done not only by the government, but, most importantly, the elderly beneficiary.

* The twilight of life is no time to impose unpredictability or additional anxieties.

# # # # #

ITEM 2

A.D.™ Alzheimer's Disease
and Related Disorders Association, Inc.
P.O. Box 9272, Mobile, Alabama 36691 (205) 438-4551 Ext. 520

1987 APR 23 AM 9 01

April 14, 1987

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Senator Richard Shelby
516 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Shelby:

I was pleased to learn that you are holding a hearing in Birmingham on April 16, 1987 on "The Catastrophic State of Catastrophic Health Care Coverage". Since I will be unable to attend, I would like to voice my concerns to you by letter.

I have served as President of the Alzheimer's Disease and Related Disorders Association, Inc. - Greater Mobile Chapter for the past three years. My interest in Alzheimer's disease comes from the fact that my Mother was a victim for 17 years. There are presently an estimated 39,000 victims in the State of Alabama and 3,000 in Mobile and Baldwin Counties. Alzheimer's disease victims live from 2-20 years. The average length of time they live is 8-10 years. There is currently no help for Alzheimer's disease victims except for the Medicaid programs which serve only impoverished persons in need of skilled nursing care. Unfortunately, although an AD victim can be totally incapacitated-not able to walk, talk, or feed themselves, the care is considered to be custodial. The families of the 2½ million victims are for the most part footing the 40 billion dollar per year cost of caring for the patients. Families are being financially devastated as they care for their loved one. I am very much in favor of a Catastrophic Health Care Bill, but one that will pay for nursing home care--not one that will pay for care in a hospital only. Why should thousands of our elderly citizens pay $5.00 per month to help pay for catastrophic care in a hospital for a few individuals when they themselves are privately paying for the care of their family member in a nursing home. This issue is of utmost importance to all of us as we are all "getting there".

Thank you so very much for your concern and consideration of this vital issue.

Sincerely,

Bunnie E. Sutton

A non-profit, charitable, tax exempt organization dedicated to Family support, Education, Advocacy and Research

ITEM 3

Statement of the American Pharmaceutical Association

The National Professional Society of Pharmacists

ON "THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE"

PRESENTED IN CONJUNCTION WITH THE HEARING HELD BY THE U.S. SENATE SPECIAL COMMITTEE ON AGING

BIRMINGHAM, ALABAMA

ON

APRIL 16, 1987

SUBMITTED BY

JAMES A. MAIN, APhA PAST CHAIRMAN
SUITE 301 AMSOUTH BANK BUILDING
931 NOBLE ST.
ANNISTON, AL 36201

American Pharmaceutical Association
2215 Constitution Avenue, N.W.
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APhA (202) 628-4410

MY NAME IS JAMES A. MAIN. I AM A PRACTICING ATTORNEY IN THE STATE OF ALABAMA. PRIOR TO MY LAW PRACTICE, I PRACTICED PHARMACY HERE IN ALABAMA. I AM PAST CHAIRMAN OF THE BOARD OF TRUSTEES OF THE AMERICAN PHARMACEUTICAL ASSOCIATION (APHA), THE NATIONAL PROFESSIONAL SOCIETY OF PHARMACISTS. APHA SUPPORTS EFFORTS TO REDUCE THE OUT-OF-POCKET MEDICAL EXPENSES OF OUR NATION'S ELDERLY. BY CONDUCTING A FIELD HEARING ON "THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE," YOU ARE TAKING A STEP FORWARD IN ADDRESSING THE NEED FOR MORE ADEQUATE COVERAGE OF EXPENSES ASSOCIATED WITH CATASTROPHIC ILLNESS.

IN ALMOST 20 YEARS OF EXPERIENCE IN ALABAMA AS A PHARMACY PRACTITIONER, COUNSELOR AND HEALTH CARE ADVOCATE, I HAVE SEEN FIRSTHAND THE NEEDS OF THE SENIOR CITIZENS FOR ASSISTANCE IN PAYING FOR PRESCRIPTION DRUGS. WE URGE YOU TO SEEK ENACTMENT OF LEGISLATION WHICH WOULD PROVIDE COVERAGE OF OUTPATIENT PHARMACEUTICAL PRODUCTS AND SERVICES UNDER MEDICARE. FOR THREE OUT OF FOUR ELDERLY AMERICANS, PRESCRIPTION DRUGS REPRESENT THEIR LARGEST OUT-OF-POCKET EXPENSES. THE ELDERLY PAY MORE THAN $6 BILLION ANNUALLY ON DRUGS. PAYMENTS FOR DRUGS REPRESENT 20 PERCENT OF THE ELDERLY'S TOTAL OUT-OF-POCKET HEALTH CARE COSTS AND AVERAGE $340 PER PERSON A YEAR. MEDICARE DOES NOT COVER PRESCRIPTION DRUG COSTS OUTSIDE OF THE

HOSPITAL. MOST MEDIGAP PLANS PROVIDE LITTLE OR NO COVERAGE OF PRESCRIPTION DRUGS. FORTY-ONE STATES HAVE NO ASSISTANCE FOR PRESCRIPTION DRUG COSTS FOR THE ELDERLY.

DESPITE THE SERIOUS LACK OF COVERAGE FOR PHARMACEUTICAL PRODUCTS AND SERVICES, DRUG THERAPY HAS BEEN SHOWN TO SIGNIFICANTLY REDUCE THE OVERALL COST OF CARE. MEDICARE COULD PROVIDE MORE COST-EFFECTIVE HEALTH CARE COVERAGE THROUGH THE REIMBURSEMENT OF OUTPATIENT PHARMACEUTICAL PRODUCTS AND SERVICES.

THE TREATMENT OF ULCERS AND TUBERCULOSIS WITH DRUGS OFFER TWO EXAMPLES OF HOW DRUG THERAPY CAN DRAMATICALLY REDUCE THE COSTS OF TREATMENT. THE INTRODUCTION OF THE DRUG CIMETIDINE IN 1977 RESULTED IN SAVINGS OF BETWEEN $3.2 BILLION AND $4 BILLION ANNUALLY IN THE TREATMENT OF DUODENAL ULCERS. THE DISCOVERY OF STREPTOMYCIN IN 1947, AND SUBSEQUENTLY OTHER DRUGS, LED TO THE VIRTUAL ELIMINATION OF TUBERCULOSIS. TUBERCULOSIS HAD BEEN THE SECOND LEADING CAUSE OF DEATH IN THE UNITED STATES AND ACCOUNTED FOR MORE THAN 50,000 DEATHS IN 1947. THE NET ECONOMIC BENEFITS FROM DRUG TREATMENT OF TUBERCULOSIS FOR THE YEARS 1947 THROUGH 1981 ARE ESTIMATED AT MORE THAN $15 BILLION. DRUG TREATMENT HAS ALLOWED MOST PERSONS WHO BECOME INFECTED WITH TUBERCULOSIS TO BE TREATED AS OUTPATIENTS.

ALONG WITH THESE WELL-KNOWN EXAMPLES, IT SHOULD BE REMEMBERED THAT IN COUNTLESS OTHER INSTANCES SIMPLE MEDICAL PROBLEMS ARE OFTEN KEPT SIMPLE BECAUSE OF THE APPROPRIATE DRUG THERAPY. ONE PNEUMOCOCCAL PNEUMONIA INNOCULATION PROGRAM LED TO A PER-PATIENT COST REDUCTION OF $84.

YOU HAVE THE OPPORTUNITY TO HELP PROVIDE COVERAGE FOR MUCH NEEDED DRUG THERAPY FOR MILLIONS OF AMERICA'S ELDERLY. SUCH COVERAGE COULD RELIEVE THE EXTREME BURDEN MANY ELDERLY ON LIMITED INCOMES MUST FACE IN MEETING OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS. COVERAGE OF PHARMACEUTICAL PRODUCTS AND SERVICES UNDER MEDICARE COULD ALSO HELP SAVE FUNDS SPENT ON OTHER HEALTH CARE COSTS.

APHA ALSO SUPPORTS EXPANSION OF MEDICARE COVERAGE TO OTHER HOME HEALTH CARE AREAS, E.G. HOME IV DRUG THERAPY. HOME IV DRUG THERAPY VIA CATHETER IS PRECLUDED FROM COVERAGE BY SECTION 1861(S) OF THE SOCIAL SECURITY ACT, WHICH LIMITS COVERAGE UNDER MEDICARE PART B TO DRUGS AND BIOLOGICALS WHICH CANNOT BE SELF-ADMINISTERED. THE FACT THAT A FAMILY MEMBER ADMINISTERS THE IV THERAPY DOES NOT VOID THE STATUTORY PRECLUSION. DRUGS, AS A BENEFIT, ARE COVERED ONLY IN CONJUNCTION WITH PHYSICIAN'S SERVICES OR AS AN OUTPATIENT HOSPITAL BENEFIT INCIDENT TO A PHYSICIAN'S SERVICES, AND ONLY IN THE CONTEXT THAT DRUGS CANNOT BE SELF-ADMINISTERED.

COVERAGE OF PHARMACEUTICAL PRODUCTS AND SERVICES UNDER MEDICARE SHOULD INCLUDE ADEQUATE REIMBURSEMENT. UNFORTUNATELY, THE MEDICAID PROGRAM PROVIDES AN EXAMPLE OF THE PROBLEMS THAT RESULT FROM INADEQUATE REIMBURSEMENT. THERE IS CONSIDERABLE COST SHIFTING AS BOTH CASH AND PRIVATE-PAY THIRD PARTY CONSUMERS ARE SUBSIDIZING THE MEDICAID PROGRAM BECAUSE OF INADEQUATE MEDICAID COMPENSATION TO PHARMACISTS FOR PRESCRIPTIONS. MEDICAID ALONE ACCOUNTED FOR 74 PERCENT OF THE TOTAL COST SHIFT SUBSIDY PAID BY CASH-PAYING CONSUMERS IN THE UNITED STATES. THE REMAINING COST SHIFTING EFFECT WAS CAUSED BY OTHER GOVERNMENT AND PRIVATE THIRD PARTY PROGRAMS. MEDICAID PRESCRIPTION PRICES WERE FOUND TO AVERAGE $1.10 BELOW THE OVERALL MEAN (ALL-PAYER) PRESCRIPTION RATE. THIS COST SHIFT EFFECT HAD A MAJOR ADVERSE ECONOMIC IMPACT UPON PRIVATE, CASH-PAYING CONSUMERS WHO HAD TO PAY, ON THE AVERAGE, AN ADDITIONAL $0.48 EVERY TIME THEY HAD A PRESCRIPTION DISPENSED IN AN INDEPENDENT COMMUNITY PHARMACY.

PRESCRIPTION DRUG REIMBURSEMENT UNDER MEDICARE WOULD BE MOST EFFECTIVE IF IT UTILIZED THE EXISTING DRUG DELIVERY SYSTEMS. THE NETWORK OF PHARMACIES AND PHARMACISTS IN THE UNITED STATES PLAYS A CENTRAL ROLE IN MAKING THE DRUG DISTRIBUTION SYSTEM IN THIS COUNTRY THE ENVY OF THE WORLD. MOST PHARMACISTS MAINTAIN SOME TYPE OF PATIENT RECORD SYSTEM AS AN AID IN ANSWERING PATIENT INQUIRIES AND TO PREVENT POTENTIAL ADVERSE DRUG REACTIONS. ELDERLY PERSONS MAY TAKE AS MANY AS 15 TO 18 DRUG

SUBSTANCES ROUTINELY, INCLUDING PRESCRIPTION AND OVER-THE-COUNTER DRUGS. THE PHARMACIST'S REVIEW OF ALL MEDICATIONS TAKEN BY A PATIENT PLAYS AN IMPORTANT PART IN AVOIDING SERIOUS DRUG INTERACTIONS WHICH MAY RESULT IN COSTLY HOSPITALIZATIONS.

THE NEED FOR COVERAGE OF PRESCRIPTION DRUGS HAS BEEN RECOGNIZED BY LEADING ASSOCIATIONS REPRESENTING THE ELDERLY. THE AMERICAN ASSOCIATION OF RETIRED PERSONS SUBMITTED A STATEMENT MARCH 4 BEFORE THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH WHICH CALLED FOR PRESCRIPTION DRUG BENEFITS FOR THE ELDERLY. THE NATIONAL COUNCIL OF SENIOR CITIZENS ALSO SAID IN ITS STATEMENT TO THE SUBCOMMITTEE ON HEALTH THAT THERE IS "AMPLE JUSTIFICATION FOR THE INCLUSION OF A PRESCRIPTION DRUG BENEFIT FOR THE GENERAL MEDICARE POPULATION." THE COUNCIL ADDED THAT THERE WOULD BE SOME OFFSETTING SAVINGS TO THE MEDICARE PROGRAM BY OFFERING PRESCRIPTION DRUG COVERAGE. A NUMBER OF YOUR DISTINGUISHED COLLEAGUES HAVE VOICED THEIR SUPPORT FOR COVERAGE OF PRESCRIPTION DRUGS UNDER MEDICARE.

APHA HAS LONG RECOGNIZED THE NEED FOR COVERAGE OF PHARMACEUTICAL PRODUCTS AND SERVICES UNDER MEDICARE. FOR YEARS WE HAVE SOUGHT LEGISLATION THAT WOULD PROVIDE COVERAGE OF OUTPATIENT PHARMACEUTICAL PRODUCTS AND SERVICES UNDER MEDICARE.

LAST MONTH, APHA'S HOUSE OF DELEGATES APPROVED POLICY IN WHICH:

- APHA SUPPORTS COMPREHENSIVE CATASTROPHIC ILLNESS INSURANCE COVERAGE THAT RECOGNIZES THE ESSENTIAL NEED FOR PHARMACEUTICAL PRODUCTS AND SERVICES IN ALL PATIENT CARE ENVIRONMENTS, INCLUDING THE HOME.

- APHA ENCOURAGES INCLUSION OF PHARMACEUTICAL SERVICES, THE MOST EFFICIENT AND READILY ACCESSIBLE SYSTEM OF DRUG DELIVERY, IN ANY INSURANCE COVERAGE FOR CATASTROPHIC ILLNESS THAT MAY BE ENACTED.

WE ARE GREATLY INTERESTED IN WORKING WITH YOU TO ENACT LEGISLATION WHICH WOULD GIVE ELDERLY AMERICANS URGENTLY NEEDED COVERAGE OF PRESCRIPTION DRUGS. PLEASE CONTACT US IF WE CAN BE OF ASSISTANCE.

ITEM 4

Statement by

FAYE S. BAGGIANO, EXECUTIVE VICE PRESIDENT

ALABAMA NURSING HOME ASSOCIATION

on

"THE CATASTROPHIC STATE OF CATASTROPHIC HEALTH CARE COVERAGE"

before the

Special Committee on Aging

of the

United States Senate

Birmingham, Alabama

April 16, 1987

STATEMENT BY FAYE S. RAGGIANO

ALABAMA NURSING HOME ASSOCIATION

APRIL 16, 1987

The Alabama Nursing Home Association (ANHA), Inc., is a statewide trade association dedicated to serving the needs of the nursing home industry in the state of Alabama. In order to serve the needs of this industry, we must examine how we serve its clients, the elderly and disabled. We are charged with the responsiblity of quality care and quality of life for the most frail of our nation's population. We presently are falling short of our goal because of a growing need for long-term care protection for the elderly.

There can be no more catastrophic health care "costs" than those incurred under long-term care in a nursing home. For too long, these costs have been overlooked by the public and private sectors. Middle-class America is suffering from the burden of long-term care costs and families are forced to face impoverishment. A solution must be found to cover "catastrophic long-term health care" expenses. It is a very real need for present-day society, as well as for generations to come.

In 1988, Medicare will outlay for services totalling about $84.5 billion. Less than one percent of this figure will cover the cost of skilled nursing home care (SNF) and only about three percent will be used to reimburse home health care services. The only other alternative is Medicaid eligibility. To qualify for Medicaid, families are forced to deplete a lifetime of savings. Even with Medicaid's contribution, in 1984, elderly individuals contributed over $12.5 billion out-of-pocket expenditures for long-term care. These figures reflect about 50 percent of all spending for this type of care.

Families are discoving long-term care averages $22,000 a year. With Medicaid and private insurance paying only a portion of this cost, the alternative is for the family to pick up the difference. Changes in society and the economy make this financial responsibility an even more difficult burden. Surveys indicate after only about 13 weeks of long-term care, many families have run through their life savings. Because there is no protection against the risk of catastrophic long-term care expenses, America's middle class faces economic ruin, and more are doing so daily.

What are the factors calling for "catastrophic long-term care coverage?

- As the "baby boom" generation reaches elderly status, the need becomes even more obvious. Fewer and fewer children have been born to the "boomers." With fewer children comes the awesome truth that someone will have to provide care for this aging society.

- Society has become more mobile. Fewer and fewer adults live in close geographic proximity to their families. The elderly are more mobile. Their children are no longer nearby to provide care.

- The structure of society has changed. More females have entered the work force, many out of economic necessity. These women have traditionally provided "care" at home for the aging. This group of "care-givers" simply does not exist as it once did.

- Another important change in society has been divorce. With more divorces taking place nationally, children of these marriages have taken a dimmer view of accepting responsibility for step-parents and aging parents, for a variety of reasons.

These are just a few examples of the many factors contributing to the need for the development of a program which protects citizens with "catastrophic long-term care" needs.

What does the future hold?

Our society is aging. According to the National Center for Health Statistics, the nursing home population today totals some 1.4 million citizens. By the year 2003, this population is expected to increase 58 percent.

In 1985, nursing home expenditures of $35.2 billion were financed about equally by public programs and private sources of payment. Public programs financed about $16.5 billion of the total, and private sources $18.7 billion. Of total private spending for nursing home care in that year, less than two percent was paid by private insurance coverage. Ninety-seven percent was paid directly by the consumer, out-of-pocket. The Medicaid program paid 42 percent, or $14.7 billion, of the nation's total expenditures for nursing home care in 1985. This total also represented nearly 90 percent of public spending for nursing home care.

But what about the future? If we are to adequately plan for our future health care needs, we must consider the existing gap in health care coverage for long-term care in a nursing home. The clock is ticking...time is running out. By the year 2000, over 13 percent of the population of American citizens will be over 65, while the number of elderly over 85 will have more than doubled.

Summary

Today's elderly grew up in an age when the average annual income was less than $500 per year. In those days, the cost of living was less and the family was the center of all care. Today, with rising health care costs, we have been forced to rely on government to assist in bearing long-term care costs. But, as we have seen, this assistance is limited and in some places, lacking.

We foresee a future of frail, aging citizens not receiving the long-term care services they desperately need if the issue is not addressed. If we are to assure generations to come quality of life, we

must address the "catastrophic health care" costs of the long-term care patient and be prepared to provide protection to families who need it.

The average citizen does not realize the danger threatened by long-term care. In a survey conducted by the American Association of Retired Persons in 1985, it was found that "some elderly believe they are adequately covered for long-term health coverage under Medicare." Others think they have coverage for long-term care through their purchase of a "medigap" policy. In the survey, 79 percent of the elderly polled believed Medicare would cover most of the cost of nursing home services. About one-third (35%) mistakenly believe that their medigap policies included extended nursing home coverage.

What an awakening when these same families sit in the administrator's office of their local nursing home and find they must either spend their loved one's life savings for just a few months of care, become impoverished to become eligible for Medicaid, and then take on the difference of what government is willing to pay and what must be paid privately...Something must be done.

The Alabama Nursing Home Association, Inc. (ANHA) would like to go on record in support of legislation designed to protect the elderly against "catastrophic" long-term health care expenses. We must face the needs of increasing numbers of elderly who require long-term nursing home care if we are to carry out our responsibility to our aged and disabled.

ITEM 5

BIRMINGHAM PODIATRY, P.C.
PODIATRIC MEDICINE – FOOT SURGERY
ADMINISTRATIVE OFFICES: 2012 EIGHTH COURT SOUTH · BIRMINGHAM, ALABAMA 35205 · (205) 324-8511

1987 APR 19 PM 2 03

Dr. Thomas S. Godfryd
Dr. Walter D. Clark
Dr. Steven M. Grunfeld
Dr. George E. Clark

April 15, 1987

The Honorable Richard Shelby
516 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Shelby:

With regard to the field hearing you have scheduled for Thursday, April 16, in Birmingham, I am pleased to file this statement for the official record. The "Catastrophic State of Catastrophic Health Care Coverage" is a subject of vital concern to all Americans, and one which is deserving of a public response. On behalf of doctors of podiatric medicine in Alabama, I commend the committee for its leadership in this critical area and welcome this opportunity to offer suggestions on its behalf.

As each of us knows, the Congress and the Administration are committed this year to a partial solution to the problem. Based on happenings in the Nation's Capital, it seems certain that a beginning step will be taken this Session to address the catastrophic acute care needs facing Medicare beneficiaries. While the pending legislation on Capitol Hill does not address the two largest categories of out-of-pocket expenditures, namely, long-term care and prescription drugs, it does lay a useful foundation on which to build. Indeed, each of us would like to do more, NOW, in response to these problem areas; but finding the ways and means to accomplish the same in an era when deficit reductions dominate the Federal scene is a challenge of gigantic proportions. But I am hopeful, indeed confident, a solution can and will be found in the foreseeable future.

What that specific solution might be is something I will appropriately defer to ones more knowledgeable and experienced in long-term care financing. But the Alabama Podiatric Medical Association is convinced that the answers will not be found within only the public or private sectors. A true partnership effort will be required to both devise and implement an effective remedy. As a minimum, that partnership should include the following:

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PODIATRIC MEDICINE – FOOT SURGERY
ADMINISTRATIVE OFFICES: 2012 EIGHTH COURT SOUTH ·
BIRMINGHAM, ALABAMA 35205 · (205) 324-8511

Dr. Thomas S. Godfryd
Dr. Walter D. Clark
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Dr. George E. Clark

The Honorable Richard Shelby
Letter - Page 2

- Public policy initiatives to encourage greater private sector involvement in the delivery and financing of long-term care.

- Public policy initiatives to provide positive incentives for private sector experimentation in the financing of long-term care.

- Broader education of the general public concerning its potential long-term care needs should be an integral part of comprehensive retirement planning.

- Public policy initiatives to encourage individual and family responsibility in this area.

- Continued state level responsibility, with improved Federal incentives, for indigent individuals in need of long-term care services.

- Creation of a regulatory environment conducive to the development and marketing of long-term care plans.

Financial protection against the costs of long-term care may well become the dominant financing issues of the 1990's. This compelling fact dictates the need for a public-private response to the issue. Government, the health insurance industry, and providers and consumers of health care services must compose this essential partnership effort. Without it, a successful remedy will be significantly impeded.

Finally, we look forward to working with the Committee and other interested parties in researching and applying solutions to the growing problem of catastrophic health care protection for all Americans. Meanwhile, we appreciate again this opportunity to share our views with the Committee.

Sincerely,

Thomas S. Godfryd, DPM
President, Alabama
Podiatry Association

2012 EIGHTH COURT SOUTH
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(205) 324-8511

103 2ND AVE., N.E.
CULLMAN, AL 35055
(205) 734-4655

ITEM 6

La Fay E. Gowan
2157 Shadybrook Lane
Birmingham, Alabama 35226

1987 APR 23 PM 2:21

April 14, 1987

Hon Richard Shelby,
Senator
Senate Office Building
Washington, D.C. 20510

Dear Richard,

Jack and I are so pleased of your appointments to such important committees. We are especially interested in the Banking Committee and the Special Committee on Aging.

I would like to present my personal observations regarding the problem of the aging from the grass-roots level.

My mother had been in a nursing home in Florida for three years with Alzheimer's disease. My father has Parkinson's disease and it became necessary to bring them to Birmingham last fall and place them in a well-run efficient nursing home so they would be near me.

The move from the nursing home in Florida was necessary, anyway, as this facility had recently been purchased by a national corporation. Then about a month after I brought my parents to Birmingham, the Birmingham nursing home was purchased by a national firm. I will address these corporations in this letter.

Richard, I hope my observations will be of some practical help to you.

Best regards

La Fay E. Gowan

Alzheimer's Care

Many nursing homes will not accept Alzheimer's patients. Many that do will keep them a certain length of time - the last stages, they will advise the family they must find other facilities for the patient's care. These "Special facilities" are few and the waiting lists are long.

Medicare only pays for medication with no assistance with the expense of the nursing home, which is an overwhelming financial drain on the spouse and family.

This disease can be long and drawn out in years draining the aged spouse of everything. not only financially but emotionally).

Nursing Homes

I am very alarmed lately of the widespread purchase of nursing homes by large nation-wide corporations who are more interested in excessive profit only, and total disregard for any "Tender Loving Care" of the elderly.

Usually, within one year of the purchase, the corporation streamlines for efficiency which means a complete turn-over of personnel, hiring only "state-required ratio to patient." Quite often the lower-wage-level new employees are undertrained to the needs of the elderly, they're usually over-worked which causes frustration. This frustration is taken out on the unprotested elderly, not only physically but by neglect and over-medication.

A well-run nursing home can be turned into a holding tank for the elderly so quickly that the family does not realize what is happening

12. Nursing Homes (Cont.)

until their parent has been harmed or neglected to the extreme. These Corporations train their Administrators as a production-line so they come out cloned. Eventually an experienced family member can recognize these administrators almost by sight.

Conclusion. Somehow this mass-purchase of nursing homes by corporations seeking the highest profit must have some more stringent State or Federal Control to protect our elderly. It has become rampant and, I fear, especially with the new tax reform, will become so out-of-hand that families will have very little choice in the near future but to put their elderly in a "HOLDING TANK" or hire private nurses to attempt to keep them at home.

This is a very serious situation that, to my knowledge, has not been addressed. A study of

(31 Nursing Homes (Cont.)

Percentage of nursing homes owned by larg National Corporations would surprise one compared to ten years ago. PROFIT VERSES QUALITY CARE

The corporation recently purchasing the local nursing home promised no increase in monthly charges for one year. Enclosed is dec. 1986 billing MARCH Version 1987 billing and a comparative "retail" cost of diapers. I call this "padding the bill!"

See HTTACHED

Mrs. Gowan attached several bills and additional information which substantiated her position on the high cost of nursing home care, as presented in her observations.

Abuse + Fraud of Medicare

by physicians closely connected to nursing homes

Normally the spouse of the one in the nursing home is billed for medical care of the patient. This spouse is elderly themself and instinctively trusts the physician and nursing home.

I have presently requested a fraud investigation regarding a physician's billing to Medicare on medical attention of my mother. I am quite sure my father would not have questioned this billing at all.

These doctors know the trick-of-the trade such as charging under $50.00 per visit as Medicare does not investigate billings under $50.00.

Medicare - Supplimental Insurance

An average 80-year old is not capable of filling out complicated insurance forms required by insurance companies. Many times they will pay the bills out of their pocket rather than struggle through many correspondence before the company pays.

At my age, I was overwhelmed at the paper-work required. I found my father had stopped filing claims years ago.

Therefore: Complicated Insurance Claim Forms = Less claims paid by Insurance Companies = More Profit for Insurance Companies.

Enclosed
cc - letter to Insurance Co.

Conclusion

As the senior citizen population ratio increases, I foresee more types of abuse of the elderly. Somehow, we must protect those that cannot protect themselves.

I see spouses selling everything and going without dire necessities because of such illnesses as Alzheimer's disease. Both the patient and the spouse have the Right of Dignity.

The high cost of Nursing homes should be Required to provide quality Care with dignity of the patient.

Fay E. Gowan

ITEM 7

1960 Old 280
Chelsea, AL 35043
April 17, 1987

The Honorable Richard C. Shelby
The United States Senate
Washington, D.C.

My dear Senator:

As promised to Mr. Dearman of your staff, I am submitting the following for inclusion in the report of the Aging Committee hearing held in Birmingham, Alabama, April 16, 1987.

It has become obvious to my wife and myself that the most important event possibly facing us is senility, compared with which the lucky ones may well be those of us who die quickly before extended hospital treatment, nursing home or other medical care make paupers of us.

This lesson has been brought home by my wife's excruciating pain from the rare disease of arachnoiditis, deepening into every fiber of her body even as she passes from a trembling paraplegic to the utter helplessness of a quadriplegic. Strong addictive drugs help deaden the pain for a time, but soon become dangerously toxic, requiring constant adjustments even while concentrating their pain-killing strength. Too quickly, mental alertness succumbs to this inexorable combination of drugs and spreading inflamation of the spinal cord, while surgery can do no more than cut growths and drain cysts from that vital organ. Complicating medical factors include serious heart-valve and blood-pressure problems requiring hospital, surgical and other extensive medical treatment.

Home care of the victim quickly becomes the primary activity of the two-member family, absorbing all available energies and resources. The husband becomes the only one to plan, drive, repair, mow, shop, pay, cook, "babe" sit, even to host, write and otherwise to keep in touch with children, family and friends - all in addition to managing the finances, and earning a living when still so active. He quickly finds that he must have help, and hires part-time cleaning assistants at considerable costs. He then finds himself unable to work, to shop, do yard work, or even to attend important business or other necessary meetings, as he cannot leave his helpless wife alone. He then hires a full-time(40 hours weekly) nursing aid with training and or experience, then adds the chores of learning, recording, paying and reporting the details of Social Security deductions for his new household staff. The extra costs quickly approach $10,000 annually and go up from there.

In the meantime, medical costs grow with many thousands of dollars required for special treatments, home equipment, facilities for wheelchair, special bed, new bathroom facilities, etc. All the while, the new routine is interrupted with increasing trips to doctors, emergency room visits and more frequent hospital stays for longer periods of time.

My wife and I are indeed fortunate in having Medicare insurance plus supplemental group coverage, which pay the bulk of our direct medical bills. But nothing covers the extra costs for home care, such as structural changes in housing for wheelchair access, acquiring a suitable vehicle to handle same, or most home medical treatment. For a short time we received assistance when a county specialist gave my wife baths, and when she was recovering from related spinal surgery we were reimbursed for temporary home therapy - which it took me two years to recover from the Medicare agent.

Thus far, we have been able to pay our regular and extra bills. The future is less sure, particularly as my wife's condition worsens, requiring intensive care, as all the doctors predict. Further, as I age into my seventies with the usual unintended consequences from living so long, our problems and related expenses will expand. We have two responsible sons with their own homes and families, but unfortunately they live far away in Washington, D.C., and New York, so we feel we must plan for ourselves.

To the extent possible, we hope to avoid nursing homes, not only because of the requirement to first bankrupt ourselves, but because it offends our sense of family responsibility. We realize that such homes may indeed be necessary as the only way to take care of some. However, we strongly believe that the first priority should be to keep the family together at home whenever possible - not only because this would be the preference for most, but because it can be done at a fraction of the cost to the immediately family and for others as well.

Yes, we urge approval, with improvements if possible, for the Administration's proposal for catastrophic medical insurance. Second, and even more important, we urge that provision be made for long-term care, whenever possible to be provided in the home.

Respectfully yours,

William C. Holcombe

ITEM 8

HUNTINGTON'S DISEASE SOCIETY OF AMERICA
ALABAMA CHAPTER
141 NEWPORT DRIVE · HUEYTOWN, ALABAMA 35023 · (205) 744-6321

ALABAMA CHAPTER
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John W. Whitaker, M. D.
Drs. Sara & Wayne Finley

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CHAPLAIN

Dr. Bill Ruprecht

U. S. Senate Special Committee on Aging
"The Catastrophic State of Catastrophic Health Care Coverage" for the Field Hearing of the U. S. Senate

Statement
of
Juanita Lantrip
Corresponding Secretary
Alabama Chapter - Huntington's Disease Society of America
141 Newport Drive, Hueytown, Alabama 35023

NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS
MEMBER

HUNTINGTON'S DISEASE SOCIETY OF AMERICA
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April 28, 1987

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CHAPLAIN

Dr. Bill Ruprecht

The Honorable Senator Richard Shelby
Hart Senate Building, Room 516
Washington D.C. 20510-6050

Dear Senator Shelby:

I am an "at-risk" person for Huntington's Disease, that means 50% chance of having this horrible disease. I have seen several members of my immediate family - father, brother and three sisters - die from this genetic disease. Only one sister is still living (not really living but a vegetable in a nursing home at the age of 39). All the deceased ones died before the age of 50. So you can see why the "Catastrophic Health Care Coverage" should be revised to include victims of terminal illnesses under the age of 65.

When an early detection becomes available for this disease, we will need the government's help in order to secure health care insurance. This is just one family, there are several thousand "at-risk" in the United States that will need this coverage.

I appreciate the job you are doing and I hope your committee will see the need for changes and additions to this program.

Juanita Lantrip
Juanita Lantrip

NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS MEMBER

HUNTINGTON'S DISEASE SOCIETY OF AMERICA

ALABAMA CHAPTER

141 Newport Dr.
Hueytown, Alabama 35023
744-6321

is associated with the Huntington's Disease Society of America, 140 W. 22nd Street, New York, NY 10011

Along with official chapters throughout the United States.

ALABAMA CHAPTER HDSA helps support:

RESEARCH ...into the causes, effects and treatment of Huntington's Disease.

ASSISTANCE....to families who need to meet social, medical and emotional problems that arise with Huntington's Disease.

EDUCATION ...of the public, both professional and lay, to awareness of the problems caused by Huntington's Disease and what can be done to correct these problems.

LOCALLY ALABAMA CHAPTER HDSA leads the community fight against this terrible disease and strives to assist the HD afflicted. One of our most important functions is informing HD families of our existence so they may realize we are people who understand and share their special problems. No longer must HD victims struggle alone.

– – – HOPE!!! – – –
for the recognition of and cure for Huntington's Disease lies in the strength of HDSA and that strength is

– – – YOU!!! – – –
All contributions to HDSA are tax-deductible.

HUNTINGTON'S DISEASE IS HEREDITARY

HD is an inherited, neurological disease, passed through the genes of an affected parent to children of either sex. HD IS FATAL.

HD parents present, to each of their children, a 50-50 chance of inheriting the defective HD gene.

HD symptoms in adults usually begin to appear between 30 and 50 yrs. the peak of life. USUALLY AFTER genes have already been passed on to a new generation.

HD genes control certain nerve cells in the brain which affect muscles in different parts of the body.

HD kills these nerve cells causing progressive deterioration which will, eventually, totally incapacitate the patient.

HD shows itself by jerks and twitches of the muscles in the head, neck, arms and legs. Speech becomes slurred.

HD persons frequently, though not always, show mental deterioration and/or marked personality changes as the disease advances.

HD is not kind. death comes gradually, taking 10 to 25 years. HD takes a terrible physical, emotional and financial toll on the afflicted and their families. OVER AND OVER AGAIN, since HD is hereditary.

HD never skips a generation. those affected may die of other causes before HD symptoms appear.

HD plays favorites. If someone in the family doesn't get the disease neither will their children and their children's children.

HD is difficult to diagnose. THERE IS NO CURE (at this time).

HD patients cling to the knowledge that this once neglected "rare disease" has become the subject of study by more doctors and scientists in the past five years than in the century since Dr. George Huntington first described HD in 1872. NEW HOPE centers around present and future RESEARCH through which a control medication and/or cure for this neurological killer will be found.

ITEM 9

HUNTINGTON'S DISEASE SOCIETY OF AMERICA
ALABAMA CHAPTER
141 NEWPORT DRIVE · HUEYTOWN, ALABAMA 35023 · (205) 744-6321

1987 APR 29 PM 3 48

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[illegible] Whitaker, M. D.
[illegible] Sara e Wayne Finley

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CHAPLAIN

Dr. Bill Ruprecht

U. S. Senate Special Committee on Aging
"The Catastrophic State of Catastrophic Health Care Coverage" for the Field Hearing of the U. S. Senate

Statement
of
O. V. Lantrip, Jr.
Chairman of the Board of Trustees
Alabama Chapter - Huntington's Disease Society of America
141 Newport Drive, Hueytown, Alabama 35023

NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS
MEMBER

HUNTINGTON'S DISEASE SOCIETY OF AMERICA
ALABAMA CHAPTER
141 NEWPORT DRIVE · HUEYTOWN, ALABAMA 35023 · (205) 744-6321

April 25, 1987

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John K. Whitaker, M. D.
Drs. Sara & Wayne Finley

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Pat Bradburn

CHAPLAIN

Dr. Bill Buerachi

The Honorable Senator Richard Shelby
Hart Senate Building, Room 516
Washington D.C. 20510-6050

Dear Senator Shelby:

While we feel it is imperative that legislation must be passed to protect our senior population from the ravages of catastrophic illness, and while we appreciate the efforts of Dr. Otis Bowen, the secretary of HHS, to initiate such legislation, we feel compelled to protest that the bill doesn't go nearly far enough. As proposed, the bill would provide coverage for prolonged hospital stays, with no provision for nursing home care. Catastrophic illness affects all age groups and this bill does not address custodial nursing home care of home health care and respite which is needed by many more people than acute care. This is unfortunate, as the significant drain on finances of the elderly as well as the young comes from confinement in nursing homes, not in hospitals. This proposed bill in its present form does not solve the problem of most families.

We also feel that something should be done for those under the age of 65, who suffer from chronic maladies that can be devastating from a financial, as well as from an emotional point of view. One should not find it necessary to lose one's life savings to a disease, nor should it be necessary to break up a family in order to qualify for state or federal aid. It is our understanding that the state of Washington has such a law, i.e., a person may qualify for state assistance in treating a catastrophic disease, without being financially destitute. This is a very humane approach to a terrible problem, and it behooves us to work toward federal involvement in such a project.

NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS
MEMBER

On February 9th, 1987, Illinois became the first state to put into effect a comprehensive health insurance plan (CHIP). Starting in July of this year, anyone residing in Illinois will be able to buy health insurance coverage, no matter how "uninsurable" they may be. The insurance companies in the state have been instructed to form a "pool" to provide coverage for these people. It will be at a higher cost in premiums than similiar coverage for "insurables", but for the first time the "uninsurable" will be "insurable"! Under this plan, many many families should be able to avoid the anguish of financial disaster which often accompanies serious injury or illness, such as Huntington's Disease. Hopefully, through the increased premiums the insurance companies will also profit from this plan. This plan can work on a national level, what Illinois hath wrought can also be wrought by our federal government.

IN SUMMARY

1. We agree with President Reagan that there's got to be a plan to help people in a catastrophic situation.
2. We feel that this plan does not go nearly far enough. Even Rep. Claude Pepper of Florida called it a timid plan.
3. We feel that the plan should include those under 65 who suffer a catastrophic illness.
4. We feel the plan needs to address the long-term care in nursing homes and include custodial care, home health care and respite.
5. We feel that legislation needs to be introduced in Congress to have the federal/state government of private sector insurance companies to offer and allow anyone to buy catastrophic insurance at a reasonable rate, so that we don't have to be financially destitute or lose one's life savings to get assistance.
6. Last but not least--the Catastrophic Insurance Act of 1987 is "fighting fires",i.e., what will the cost be? How do we finance it? Who is to be covered? What kind of coverage is needed? Should individual insurance companies cover more? How will it change the medicare and medicaid programs? Should nursing homes be included? When should it become effective and list goes on. These are the fires that we are fighting today and we'll be fighting them tomorrow and well into the future, unless we start working harder and faster on our fire prevention program, which is

simply genetic research. Until we cure the problem (genetic disorders), all we'll ever be doing is putting out fires! "Let's get out of the fire fighting business".

It is our sincere hope that your public hearings will bring forth needed creative solutions on these issues---- the good news is that at least people are talking about the issues instead of sweeping them under the rug.

O. V. Lantrip, Jr.
Chairman of the Board of Trustees
Alabama Chapter/HDSA

ITEM 10

Statement of
Andrew P. Hornsby, Jr., Commissioner
Alabama Department of Human Resources

Senator Shelby, thank you for the opportunity to submit a statement representing the views of the Alabama Department of Human Resources regarding catastrophic health care coverage. My name is Andrew P. Hornsby, Jr. and I am Commissioner of the Alabama Department of Human Resources.

Alabama's elderly population is steadily increasing. According to the latest Population Report released from the Center for Demographic and Cultural Research, Auburn University at Montgomery, the number of Alabama residents, aged 60 plus, has increased approximately seven-fold since the turn of the century, now amounting to over 16 percent of the total state population. According to the U.S. Bureau of the Census, the elderly (defined as aged 65 plus) are expected to comprise nearly one-fifth of the total U.S. population by the year 2020. Such projections are not available for Alabama, but similar trends can be expected within the state. We can only expect that problems currently identified in health care of the elderly will be magnified as the percentage of aged population increases.

We appreciate the concern and attention being given by the Reagan administration to the problems associated with catastrophic illnesses. As we understand the proposed legislation supported by President Reagan, for a minimal monthly premium, Medicare would cover an unlimited number of days in a hospital with a $2,000.00 annual cap on coinsurance and deductible payments. Based on our Department's experience with the indigent elderly and the elderly of other socio-economic groups, we believe that many elderly people do not have sufficient resources to pay a $2,000.00 co-payment or deductible at any one time. The Reagan supported legislation apparently calls for no payment for prescription drugs, dental care, or routine eye care, which we have found to be badly needed changes.

Based on our contacts with clients, we can document the need for increased coverage for long and short hospital stays, home care, and nursing home care. We also see a need for clearer definition of county government's responsibility for uncompensated care, increased eligibility for Medicaid, and increased employee insurance coverage for longer periods of time. Most of these measures require additional revenue on state and county levels.

Alabama currently has a serious gap in public and private health insurance coverage of expenses associated with catastrophic illnesses. The most serious problems appear to be associated with long-term institutional care of the elderly.

There is considerable competition for available nursing home beds in Alabama. Nursing homes generally maintain waiting lists for available beds and accept the patient who has the greatest financial resources and the greatest probability of being able to pay for all services he receives in the nursing home. Costs of nursing home care in Alabama currently ranges from approximately $1,200.00 - $1,500.00 per month. Few individuals can afford this expense for very long. While there are some insurance policies available that pay for nursing home care for up to four years, these are expensive and are not generally affordable by our clients. We are receiving an increased number of neglect reports in which families abandon their elderly relative in the hospital because of the family's inability to financially sponsor nursing home care or assume any additional responsibility for at-home care.

While the Medicaid program pays for certain nursing home services for those who qualify, it does not pay for all expenses. Expenses not covered by Medicaid must be paid by a patient sponsor or absorbed by the nursing home facility. Problems such as these have made it increasingly difficult to locate nursing home placements for Medicaid patients who have no one to serve as patient sponsor. The Alabama Department of Human Resources does not have funds to act as patient sponsor, nor do most city and county governments.

On the other end of the illness spectrum is the elderly person who is ill but wishes to remain at home and could safely do so with some community support services. The individual with a catastrophic illness must meet the needs criteria established for Supplemental Security Income (SSI) or State Supplementation (SUP) to be eligible for Medicaid which, in many cases, pays for more community based services than does Medicare. Those who qualify for Medicaid are eligible for payment for most prescription drugs after paying a small co-payment, visits to physicians, and a limited number of days in the hospital. There is no mechanism for an exception to exceed the limited number of hospital days. Therefore, when Medicaid patients require further hospitalization, the cost must be absorbed by the hospital or county government through quickly depleted Hill-Burton funds or other local resources.

Our state is facing many problems related to health care and we have fewer and fewer dollars to meet those needs. It seems imperative that we make changes in both the Medicare and Medicaid programs in order to provide needed care and services to our elderly citizens. How those changes are made requires considerable deliberation. We are hopeful that hearings such as this one will enhance the knowledge of all decision makers so that the most equitable plans can be developed for providing quality health care to all elderly citizens.

ITEM 11

STATEMENT OF

J. MICHAEL HORSLEY

COMMISSIONER

ALABAMA MEDICAID AGENCY

Presented to the

Senate Special Committee On Aging

Following a Field Hearing in Birmingham, Alabama

on the subject of

"The Catastrophic State of Catastrophic

Health Care Coverage"

On April 16, 1987, the Senate Special Committee on Aging held a field hearing in Birmingham, Alabama, on the subject of "The Catastrophic State of Catastrophic Health Care Coverage." As Commissioner of the Alabama Medicaid Agency, and on behalf of Governor Guy Hunt, this statement is presented for inclusion in the record of that hearing. The Medicaid program in Alabama pays for health care of more than 300,000 individuals annually. The program serves low income citizens, including mothers and children, the elderly and the disabled. Without Medicaid, these individuals would not have access to basic health care.

People who are 65 years of age and older comprise 26 percent of those who are eligible for Medicaid in Alabama. These individuals are high users of health care; services to this population represent 44 percent of total payments for medical services. Last year, Medicaid payments in Alabama totalled $410 million, and payments on behalf of the elderly population totalled $181 million.

Nursing home care, which, by far, represents the greatest single expenditure for Medicaid in Alabama, comprises 31 percent of total expenditures. Since Medicare does not cover long-term care, this service is funded primarily by Medicaid. Very few insurance companies--including those providing "MediGap" policies--cover long-term care. An estimated 62 percent of those living in nursing homes in Alabama benefit from Medicaid. Elderly people who enter nursing homes as private-pay patients often become eligible for Medicaid through spending-down of resources.

As our population ages, our nation faces the challenge of designing and delivering services that meet the needs of the elderly. The needs of people 65 and older are as varied as the individuals themselves, and government cannot be the only or even the primary source of funding. Elderly people and their families have responsibilities, as do volunteer and private organizations such as insurance companies.

Very likely, there will always be a need for nursing homes, but alternatives to institutionalization are coming to the forefront as the preferred means of care. Home- and community-based services, as well as residential services such as those offered by domiciliaries, are among the already available alternatives that could be expanded to serve more people. Services at home and in the community have demonstrated cost effectiveness as administered through Medicaid. Domiciliaries, though not governmentally financed, are beneficial for people who do not need nursing home care but, for whatever reason, cannot live at home. At the end of the 1986 fiscal year, Alabama had 125 licensed domiciliaries; the number of these facilities has increased dramatically in recent years, and that trend is expected to continue.

Alabama's home- and community-based program for the elderly and disabled provides five services: case management by social workers, homemaker services to assist with household tasks such as cooking and cleaning, personal care to help with activities such as eating and bathing, respite care to give relief to those usually in

charge of care, and adult day health care in approved facilities. This program, made possible by a federally approved waiver, serves about 4,200 Medicaid eligibles who meet the state's medical criteria for nursing home care. Now in its third year of operation, the program will be renewed for five years with federal approval. Whereas care in a nursing home costs the Medicaid program almost $800 a month, home- and community-based services are currently delivered for just over $300 a month for each individual.

As long as services at home continue to demonstrate cost effectiveness, and as long as the quality of care continues to be high, the Alabama Medicaid Agency will support this method of service delivery. The program is extremely popular, and many areas of the state have waiting lists. People usually want to stay at home if at all possible. Most of those served by Alabama's waiver are over 75 years old, and they have a variety of health problems, ranging from arthritis to heart disease. Most live with someone who takes a great deal of responsibility for their care, but a surprising number live alone.

Because of the demonstrated cost effectiveness of home- and community-based services, and because of the evidence suggesting that people prefer home care, national health policies should take into account the need for non-institutional methods of service delivery. A recent study by the General Accounting Office found that 3.2 million Americans need home care in order to avoid institutionalization. While many of these citizens receive all the home care services they need, many do not. The GAO study, which

focused on the characteristics of Medicare beneficiaries, found the greatest unmet needs involved getting assistance to improve mobility. The most frequently reported unmet needs involved assistance in getting in and out of bed, in getting around inside the house, in walking around outside the house and in transportation. The GAO study found that only about a fourth of those with unmet needs are Medicaid eligible, thus suggesting that the nationwide impact of the Medicaid waiver program is limited. The study definitely shows that the need for services at home is largely unmet. This finding contrasts with prevailing opinions focusing on institutional care as the primary means of delivering long-term care.

Limited as they are, neither Medicare nor Medicaid can carry the entire burden for the financing of long-term care, whether inside or outside institutions. A few insurance companies are beginning to offer long-term care policies, but such coverage by private insurers is by no means common. Health maintenance organizations are also a source of coverage in some instances, but they are not the norm, either. Government can play a role in expanding private coverage by exploring the possibility of offering incentives for companies to develop long-term care policies and for individuals to purchase them.

Two of the measures proposed by President Reagan to deal with the high cost of catastrophic illness definitely deserve serious consideration in alleviating public misconceptions and encouraging savings for long-term care. One of these measures calls for a

public education program, conducted in conjunction with private insurance firms and other groups. It would attempt to correct the widespread and serious misconception that Medicare and private policies provide comprehensive long-term coverage. Another would require the Treasury Department to study ways of encouraging private savings for long-term care. These would include individual medical accounts (IMA's), which would be similar to individual retirement accounts (IRA's). The money in IMA's, however, would be used to provide for long-term care. Whether through IMA's or another method, private savings need to play a major part in solving the long-term care problem. Methods of financing long-term care need to include provisions for financing both institutional and at-home services.

Medicaid is often criticized for its spend-down provisions with regard to nursing home care. This criticism is not justified, in view of the fact that Medicaid exists to serve those who cannot afford to pay for their health care through private means. Spend-down policies and resource and income limitations exist to contain costs, prevent abuse, and assure that people meet their own needs insofar as possible. Unfortunately, the growing reliance on Medicaid to pay for nursing home care has, in many instances, led to a deterioration in the sense of family responsibility that prevailed before government assumed such a broad role in the delivery of health care and social services.

Because long-term care for the elderly is so expensive, any discussion of the cost of catastrophic illness usually focuses on

the varied needs of older people. Obviously, however, catastrophic illness and its accompanying expense can strike anyone. Advances in medical technologies and treatment of illness have brought a mixed blessing. For a chance of survival that might be quite small, people who are candidates for heart transplants, liver transplants, bone marrow transplants, lung transplants and other new and expensive procedures face enormous expense, much of it uncovered by any insurance, public or private. It is possible that our nation simply cannot afford to subsidize some of the complex and costly new procedures and technologies. If new and experimental techniques are subsidized, standards must be set to determine who will benefit from these forms of health care delivery.

For the future, an emphasis on preventive health for all Americans may offer part of the solution to the problem of catastrophic illness. Public education programs have succeeded in reducing the number of people who smoke, although stepped-up efforts are needed if a "smoke-free" society is to become a reality. Public education stressing the benefits of nutrition, diet and exercise has become more prevalent than it was a few years ago, and many people are taking heed of advice designed to help them live fuller, longer, healthier lives.

The Alabama Medicaid Agency and the Alabama Department of Public Health are co-sponsors of a Preventive Health Council composed of prestigious health professionals and representatives of interested groups from throughout the state. Through this Council

and educational efforts such as conferences and media campaigns, Alabama is striving to encourage healthier lifestyles among its citizens. Specifically for the Medicaid population, emphasis has been placed on increased utilization of the health screening program for children, and the Preventive Health Council has been asked to make a study of the probable costs and benefits of a screening program for adults. Preventive health offers a realistic and sensible means by which people can assume a great deal of responsibility for their own care. In the long run, money can be saved as people remain healthier longer.

In planning for a national approach to catastrophic or long-term care, public funding must not be viewed as the only or the primary solution. Private insurers, volunteer organizations, individuals and their families have significant responsibilities. Government can play a major role in educating people to the limitations of Medicare and Medicaid and encouraging all Americans to adopt healthy lifestyles. Proposals such as the idea of Individual Medical Accounts should be explored as possibilities for encouraging savings for long-term care. People need to plan for their old age when they are young, before the need for care arises.

ITEM 12

STATEMENT OF

GEORGE E. HUTCHINSON

OF THE

ALABAMA ASSOCIATION OF HOME HEALTH AGENCIES

BEFORE THE

U.S. SENATE SPECIAL COMMITTEE ON AGING

APRIL 16, 1987

Mr. Chairman and Members of the United States Senate Special Committee on Aging.

I am George Hutchinson President of the Alabama Association of Home Health Agencies. I am also Executive Director of Central Alabama Home Health Services, Inc. of Montgomery, Alabama.

The Alabama Association of Home Health Agencies (AAHHA) is a state association representing the majority of home health providers in Alabama. Its members are government operated, hospital based and free standing agencies and are both non-profit and for profit entities. Our Association is dedicated to assuring the availability of humane, cost effective, high quality home care services to all who require them.

I am pleased to have the opportunity to present a statement to this Committee on the issue, "The Catastrophic State of Catastrophic Health Care Coverage". AAHHA and the national associationsrepresenting home health support the concept of catastrophic coverage and benefits for those whose medical needs exceed the present Medicare, Medicaid and private insurance coverages. We recognize that budget resources for such a program are extremely limited. It is therefore essential that Congress draft legislation to stretch the limited funds as far as possible. To achieve this, AAHHA strongly urges you to support inclusion of a cost-saving home health provision as you consider proposals currently before your Committee.

We are pleased that discussion of proposed Catastrophic Health Insurance proposals has increased public awareness about the actual "catastrophic" health needs of the elderly. However, the fundamental health care need of elderly Americans is not coverage of costly "catastrophic" acute illness, but rather the coverage of the far more costly care needed for chronic conditions. Granted that acute illnesses can be very costly, But, with the average stay nationally of a patient in a hospital being now in single digits and the emphasis Congress has placed on health care delivery systems to implement more cost effective, non-institutional alternatives, we submit that improved long term care coverage will more effectively alleviate catastrophic hardships of the elderly.

While Congress addresses the needs of the elderly confronted with catastrophic health and financial burdens, it should also correct the existing problems that beset the elderly in the Medicare and Medicaid programs. Such corrective

action would reduce the number of recipients needing catastrophic health coverage in the long run.

On January 23, 1987, the General Accounting Office submitted its report, "Discharge Planners Report Increasing Difficulty in Placing Medicare Patients" wherein it stated that based on its survey Medicare program rules and regulations were the most important barrier to posthospital care for patients.

We concur with their findings and submit that if Medicare Home Health Benefits were broaden to cover more acute care needs and chronic care needs then there might be less catastrophic hardships endured by the elderly.

Immediate corrective measures that could be enacted by Congress are clarifying definitions in the present law, expanding services to include care of chronic illnesses and improving the quality of care. All of which would remedy problems in the current Medicare Home Health Benefit that are limiting access to the benefit for many Medicare beneficiaries.

Further, we submit that the Catastrophic Health Care Program should include the following:

* That the private sector be encouraged to offer long-term care insurance policies which supplement Medicare. In addition consumer savings to meet long-term care needs should be encouraged through tax-deductions or tax-deductible individual medical accounts.

* Home care benefits for those not already receiving home health care.

* Home care services for those who would have to be or remain institutionalized without home care services.

* A screening process for determining the needs of the patients and selecting the appropriate alternative level of care when feasible leaving institutional care as the last resort.

* Financial support adequate to fund the program

* Elimination of coinsurance and deductibles

* Elimination of the spell of illness concept

* Provisions for hospice services

* Provisions for coverage of certain drugs, available by prescription only.

In summary, we thank you for the opportunity to make our concerns known. We urge this Committee to consider these positive suggestions in establishing a Catastrophic Health Program. We suggest that there are measures that can be taken to move health care away from the costly institutional model contained in Medicare. Providing expanded home health benefits within a comprehensive long term care program will establish a basis for doing this.

Here is an opportunity for Congress to point the way to less costly alternatives to institutional care. I hope this Committee is in agreement.

Respectfully submitted

George E. Hutchinson

George E. Hutchinson
President
AAHHA
1017 Ann Street
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ITEM 13

The Medical Association
of The State of Alabama

S. Lon Conner
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19 S. Jackson
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April 13, 1987

The Honorable Richard Shelby
516 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Shelby:

This is in response to your cordial invitation of April 2 to comment on catastrophic health care coverage in advance of the public hearing of the U.S. Senate Special Committee on Aging in Birmingham April 16.

The title of the hearing, "The Catastrophic State of Catastrophic Health Insurance," seems to imply a conclusion has already been reached in the matter, and there remain only the problems of defining coverage, beneficiaries and solutions, by which is meant federal solutions.

The problem, narrowly defined, is of course very real and one with which virtually all physicians must deal from time to time. But in all the national discussions we find considerable disagreement on a definition of catastrophic. Obviously, some Medicare recipients would be devastated by an illness costing several thousand dollars while others would not be. Additionally, it appears that the catastrophic concept is still expanding to cover other than the aged, as witness Rep. Claude Pepper's recent announcement that he will introduce a bill shortly to insure that all Americans, regardless of age, will be able to afford catastrophic care.

He and others also believe that any catastrophic bill should, sooner or later, cover long-term care, since the financial impact of such care is often as devastating, over time, as catastrophic acute illness.

More than 20 years ago organized medicine supported what was essentially a catastrophic alternative to Medicare, which was called Eldercare. It lost. At the time, the greater popular interest was in first-dollar coverage, which would, medicine argued, bankrupt the system at some point.

If, as presently defined, catastrophic health coverage would be limited to a few Americans -- one number mentioned has

been 39,000 -- that would be one thing. If the number is millions, obviously this would be quite another. What are we really talking about?

Congress may have put the cart before the horse in enacting the present Medicare before some kind of catastrophic bill, which would have fitted the insurance concept of protection against major losses much more rationally than does Medicare, which advances the notion that everyone over 65 is entitled to some care.

In this way our resources were spread about in a manner that seemed, to Congress, to satisfy the Jeffersonian catechism of doing the most good by the most people. True catastrophic coverage, as we understand it, seeks to do good by a minority and to somehow fit this into a self-sustaining program of voluntary premiums by Medicare beneficiaries.

The history of medical cost prediction in this country is a history of vast underestimation and overpromising. Congress has not, and probably will not, adequately fund existing Medicare to that level sufficient to guarantee all it has promised. As a consequence, conventional Medicare benefits are now rationed in the United States, although no one uses that term, because demand has outstripped the national resources that we, as a people, are willing to commit.

It is against this background that we confess to some uneasiness about the catastrophic proposal. If enacted, it can be predicted with some confidence, it will be expanded far beyond its capacity to support and will accordingly be rationed, just as Medicare is now. Within a few years of passage, perhaps even immediately, it will be discovered that utilization exceeds available resources and that actuarial predictions were far off the mark.

These reservations may seem heartless but physicians have seen the faces of many, many Americans who thought Medicare covers far more than it does. Almost certainly this will be the fate of catastrophic care.

If this were an ideal world of infinite resources, catastrophic add-on to Medicare might be entirely appropriate. Certainly, most people in the risk group would like to have it. Certainly, physicians have seen many cases of elderly Americans swamped by costs of a major illness. But in a

time of fiscal retrenchment, a time when Medicare is, year after year, subjected to the budget-cutting ax -- is this a time to enact legislation to expand the federal obligation, when present obligations are not being met?

In determining the threshold of catastrophic illness and whether or not means-testing is a valid factor in that threshold, the Congress may ultimately be forced to consider present Medicare as a program for the poor only. This would effectively disqualify many millions of aged Americans who have been led to believe federal health care after 65 is both an insurance contract and an entitlement. The political fallout from such an about-face would be massive, as Medicare became, in substance, a national Medicaid program.

In sum, we believe that catastrophic add-on will inevitably add to the acute fiscal problems of the Medicare program. We place little faith in predictions that it can be financed out of a small monthly surcharge to beneficiaries. Cost overruns in Medicare forecasting eclipse even those in defense allocations.

In addressing any national proposal of this magnitude, it is instructive, we believe, to reflect on a warning by the General Accounting Office in another context: the American people often confuse wants with needs. Obviously, many millions would want catastrophic coverage but only a few thousand may actually need it.

If the program could be held to genuine cases of catastrophic illness, the few thousand that occur annually, we would be disposed to favor it. But if the catastrophic yardstick is to be subject to change to accommodate more cases of want rather than need, that is plainly something else.

One commentator has pointed out that a major element of the demand for catastrophic coverage is from younger generations who want to protect their potential inheritances from dissipation on the health care needs of their aging parents. It is not the function of government to protect legacies.

While none of the above may appear germane to your meeting title, "The Catastrophic State of Catastrophic Health Insurance," it may touch obliquely on the catastrophic debate that has emerged on this issue. Catastrophic seems to mean different things to different people. Our fear is that it will, in the legislative process, be expanded into another empty promise of all things to all people. And that would be a disaster for the already troubled Medicare program.

Thank you for the opportunity to provide some of the thinking of Alabama doctors on this issue.

Sincerely,

S. Lon Conner
Executive Director
Medical Association of the State of Alabama